FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Los Angeles

Conducted on

April 25-28, 2016

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INTRODUCTION

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of Managed Care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

- MHP information:
  - Beneficiaries served in CY14—161,888
  - MHP Size—Very Large
  - MHP Region—Los Angeles
  - MHP Threshold Languages—Spanish, Vietnamese, Cantonese, Mandarin, Other Chinese, Armenian, Russian, Tagalog, Korean, Farsi, Arabic, Cambodian
  - MHP Location—Los Angeles

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Los Angeles mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC). In addition to this, the regional areas reviewed in detail included Service Area 4 and Service Area 6.

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Los Angeles MHP submitted two PIPs for validation through the EQRO review. The PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES[3]

Utilizing the Information Systems Capabilities Assessment (ISCA) protocol, the EQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included review of the MHP's reporting systems and methodologies for calculating Performance Measures (PM).

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

The EQRO examined available consumer satisfaction surveys conducted by DHCS, the MHP or its subcontractors.

CalEQRO also conducted four 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

(5) KEY COMPONENTS, SIGNIFICANT CHANGES, ASSESSMENT OF STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT, RECOMMENDATIONS

The CalEQRO review draws upon prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

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[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY14-15

In this section we first discuss the status of last year's (FY14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY14-15

- Recommendation #1: Convene focus groups involving multiple stakeholders for identification of concerns related to the planned department merger; utilize multi-media technology for those who are unable to attend in person.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - On February 16, 2016, the System Leadership Team (SLT) held a discussion focused on stakeholders' perceptions and experiences regarding the new Los Angeles County Health Agency. This was a follow up to the prior year EQRO recommendation to conduct focus groups to address stakeholder concerns about the formation of a new Health Agency.
  - It should be noted that SLT members expressed concerns about the survey, realizing, in retrospect, it should have been conducted before the formation of

the new Health Agency. The facilitator acknowledged these concerns and the MHP provided a summary of the responses. The survey appeared comprehensive and covered various themes such as information, collaboration, input, and changes affected by the transition.

- Given the timing of the recommendation, which followed the formation and transition to the Health Agency, EQRO agrees the MHP did as much as possible with its efforts to include stakeholders of the merger.

- Recommendation #2: Identify a minimum set of individuals who would routinely receive Strategies for Total Accountability and Total Success (STATS) reports, such as all Quality Improvement Division (QID) central and Service Area/Quality Improvement (SA/ QI) staff, not leaving this to the judgement of District Chiefs or other individuals. This process will assure all QI involved individuals at same levels receive the same information about the department's performance tracking efforts.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - In November 2015, the Quality Improvement Manager, under the Program Support Bureau, Quality Improvement Division (PSB-QID), identified the list of the SA and QID Central staff who would routinely receive STATS reports and received approval from the Executive Management Team (EMT).
  - This list was provided to the appropriate Chief Information Office Bureau (CIOB) staff. All SA QIC Chairs and QID central managers and QI leads were granted access to the STATS reports on November 19, 2015.
  - The decision was brought forward as an agenda item and announced during the central QID meeting.

- Recommendation #3: The MHP should consider the establishment of a universal timeliness feedback mechanism published at each intake site, which directs all consumers to provide feedback to the MHP on the timeliness and adequacy of service response.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - To develop a timeliness feedback mechanism, the MHP included two questions on the consumer satisfaction survey administered by the Office of Consumers and Family Affairs (OCFA) in the Fall 2015. These questions were:
    - ▷ Is this your first appointment at this clinic today?
    - ▷ If yes, how satisfied are you with the timeliness of this appointment?
    - ▷ A choice is provided on a 5 point Likert scale ranging from "Very Satisfied" to "Very Dissatisfied" for consumer response.
  - This survey was administered at 20 directly operated clinics and five contract clinics. Although the survey was not administered at all intake sites, the survey

sample from the Fall 2015 OCFA survey at these 25 clinics provides important information on the perception of timeliness and adequacy of service response.

- ▷ A total of 932 surveys were completed, of which 161 (16.6%) were received from consumers who were visiting the clinics for the first time.
- ▷ More than three quarters (79.3%) of the consumers visiting the clinic for their first time were very satisfied or satisfied with the timeliness of the appointments offered by the clinic.
- ▷ Further, 81.9% of the consumers who had previously visited the clinics were very satisfied or satisfied with the timeliness of the appointments and 83.2% indicated they were treated with respect over the past three months.
- ▷ When asked if they were satisfied with the overall services at the clinics, 90.3% of the consumers said yes and 95.4% were satisfied with the cleanliness of the clinics.

- o The MHP provided a summary report which highlights other findings of this survey.

- Recommendation #4: Continue to work with Human Resources on an evaluation of positions, such as the Medical Caseworker, that may be suitable for the substitution of work experience for educational requirements on a year by year basis.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- o The MHP requested approval from the County of Los Angeles Chief Executive Office and Board of Supervisors for a Community Services Counselor position in the MHP budget. This position of Community Services Counselor position is intended to be a promotional opportunity from the position of Senior Community Worker that does not require any formal college education.
- o The Office of Consumer and Family Affairs (OCFA) requested one Community Services Counselor item in lieu of hiring for a Community Worker in their FY16-17 budget. The request was denied by CEO on December 29, 2015 and appropriated as a Senior Community Worker, considered a rank below the Community Services Counselor. Although the county specifications for Senior Community Worker and Community Service Counselor are very similar, the job description did not meet the higher standard.
- o After consulting with the MHP's Human Resources (HR) Manager, the next step is to complete a review of the current Senior Community Workers and a classification study by HR. This will provide a class understanding for career ladder endeavors.
- o While the MHP is bound by Civil Service Rules in its hiring practices of people with lived experience, the Executive team is making an effort to implement change and expand opportunity for these individuals. With the direction of the

State toward enacting peer and family support specialist certifications, the MHP has been training and employing peers, parents and family members on treatment teams since MHSA inception. Continuing along the lines of the state certification of peers, multiple programmatic and training opportunities exist for peer inclusion on treatment teams.

- The MHP is committed to expanding the Peer Workforce and value peer employees. OCFA has several Statements of Work (SOWs) for peer trainings in the works to determine testing requirements, looking at the peer position nationally to model. OCFA has several peer specialist position curriculum development SOW's, such as a Peer Housing Navigator Specialist, a Peer Correctional Specialist, a Peer Shelter Navigator Specialist.
- Multiple endeavors continue to exemplify the value of peer employees, such as the following:
  - The Adult System of Care (ASOC) continued to support peer inclusion activities and the establishment of a strong foundation for a peer career path. ASOC facilitated and sponsored peer programs including Wellness Outreach Workers (WOW), Clinic Ambassadors, Los Promotores De Salud Mental, and Support Groups in Spanish. ASOC staff facilitates monthly meetings with the group facilitators and regular visits to the support group to monitor their volunteers and to develop their skills.
  - Promotores are health promoters who provide mental health related trainings at various locations throughout their community. During the past fiscal year, their attention has been focused on the Latino communities of Service Area 7 and Service Area 8. Service Area 7 trained five additional Promotores and Service Area 8 trained 19 during their implementation year.
  - ASOC coordinated the four-day Clinic Ambassador trainings provided by Mental Health America (MHA). Additionally, ASOC coordinated and/or sponsored peer development trainings that improved their skills to provide peer support and enhanced their resumes for obtaining employment as Mental Health Advocates or Community Workers.
  - WOW volunteers are trained consumers and family members with lived experience who provide peer support in our directly operated adult programs and are eligible to receive a small stipend. The WOW program continued to grow with 54 new WOW trained during FY 14-15 bringing the number of trained WOW to 437 individuals since the program's inception in 2011. During the past year, WOW volunteers provided over 11,000 total days of peer support in 18 directly operated programs and 15 community settings.
  - The Clinic Ambassadors are specially trained WOW who assist clients in the waiting areas of our directly operated programs. Their role is to

create a welcoming, engaging, and safe environment in the waiting area. Creating such an environment in the waiting room has proven to reduce security and safety incidents.

- ▷ Support Groups in Spanish are peer support groups facilitated by trained mental health consumers and family members in various community settings including churches, libraries, community centers, and Wellness Centers who receive a small stipend.

- Recommendation #5: Continue to provide technical assistance to those legal entities and EHR vendors who have not yet successfully completed the Integrated Behavioral Health Information System (IBHIS) Go-Live Readiness workflow.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - In January 2016, the MHP reviewed and prioritized its active project list to 18-20 critical projects with staffing deployed as necessary to these identified projects. The task to incorporate the Legal Entity (LE) readiness and on-boarding to IBHIS was placed on the short list of critical projects. Other projects were deferred or terminated.
  - Since January 2, 2016, the MHP added four more legal entities to those already operational on IBHIS. Rollouts are suspended in March 2016 while some substantial improvements to Legal Entity practitioner maintenance and claims processing are tested and deployed. These changes are viewed as essential to managing a high volume of Legal Entity providers.
  - There are also refinements to the Legal Entity and Fee-for-Service on-boarding process being reviewed that, if successful, will streamline the process. Rollouts resume in April 2016. In August 2016, Pacific Clinics, the largest Legal Entity provider contracted with DMH, will be operational on IBHIS.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality, including those changes that provide context to areas discussed later in this report.

- Access to Care
  - The MHP has prioritized its psychiatry strategies with the following:
    - ▷ Workflows are currently being developed to utilize the MHP's Telemental Health Network in order to provide linguistically and

culturally matched care to clients requesting services in certain threshold languages.

- ▷ The MHP is considering broadening the types of mental health services that are delivered utilizing video teleconferencing strategies to include psychotherapeutic interventions that could be delivered by non–medical mental health professionals.
- ▷ The Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) program offers Field Capable Clinical Services (FCCS) to older adults, ages 60 and above. FCCS offers an alternative to traditional mental health services for older adults who may be unable to access services due to impaired mobility, frailty, or other limitations. Older adults who may be uncomfortable seeking services in a traditional clinic, FCCS may be a welcome alternative.
- ▷ The MHP is heavily invested in electronic consultation. It is currently collaborating with the Department of Health Services (DHS) on an eConsult initiative aimed at providing timely appointments for those patients that require specialty mental health services. The MHP is also in the final stages of negotiation with LA Care in which the MHP's psychiatrists will provide consultation to primary care providers in the LA Care Network.

- The MHP Mobile Triage Teams (MTT) began in Spring 2015 which target people who are homeless, veterans and/or older adults. The MTTs are directly operated program and there is one team of 8 staff in each of the eight Service Areas (SA). The MTTs provide field-based triage and assessment of individuals/families to determine eligibility for DMH services and for those that are eligible to actively link them to the appropriate on-going services.
- In July 2015, the ACCESS Call Center and Emergency Outreach Bureau (EOB) Psychiatric Mobile Response Teams (PMRT) went "live" with the integrated IBHIS replacement for the stand-alone custom ACCESS Center Call Management (ACCM) system for logging all calls to ACCESS, Patient Transportation Orders, acute psychiatric bed authorizations for indigent clients and PMRT dispatches. Using this solution, incidents can be "passed" back and forth between ACCESS and PMRT staff as necessary.

- Timeliness of Services
  - The Augustus F. Hawkins Clinic has worked to provide same-day assessment to the majority of those who walk in requesting service. It is supported by providing several, or more, group sessions following the initial intake; the group sessions are run by the consumer's ongoing therapist. Due to the rapidity of initial access and appointments, initial time to psychiatry is reduced, and at this time no-shows for psychiatric appointments are also reducing. This is seen as associated with the

elimination of the typical long interval between initial assessment and prescriber appointments, which many consumers fail to follow.

  - Crisis Transition Specialist Teams have been established at Urgent Care Centers (UCC) and provide intensive case management for up to 60 days following discharge to ensure stabilization, linkage to on-going services within the local community.

- Quality of Care

  - Significant retirements among leadership and other key personnel have resulted in changes within upper management. Fortunately, those currently functioning in an "acting role", until these vacant positions are filled, have significant departmental leadership experience.
  - With multiple leadership changes, relatively minor adjustments were indicated, stakeholders implying a seamless transition and demonstration of confidence with the in-coming leaders.
  - In an attempt to improve both access and quality of care, several agencies in eight geographic areas across the county have joined together to pilot Health Neighborhoods. Participation was initially focused on health, mental health, and substance abuse and public health agencies and expanded to include community services regionally based.
  - The MHP has worked with various police departments to customize the agreements and develop plans to implement collaborative team response in various communities. Formal trainings such as the Mental Health Intervention Training were offered.

- Consumer Outcomes

  - To expedite service delivery for the Katie A subclass, the MHP engaged in an "Immersion Strategy". Immersion envisions additional investment of resources within two geographic units initially, with the expectation to expand countywide. The immersion period provides an opportunity to re-examine and re-design existing systems to better integrate Core Practice Model (CPM) principles and to develop the mental health resources necessary to support the shared DMH and Child Welfare System goals of child safety, permanency and well-being.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP

- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2016.

TOTAL BENEFICIARIES SERVED

Table 1 provides detail on beneficiaries served by race/ethnicity.

Table 1—Los Angeles MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

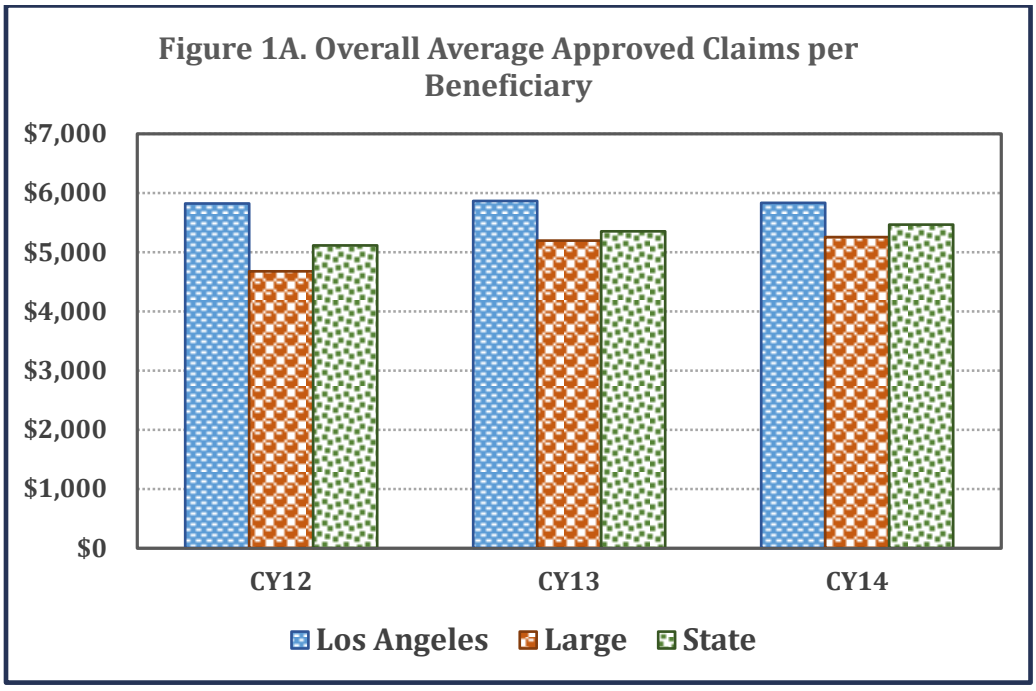
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	330,150	34,350
Hispanic	1,753,698	73,098
African-American	273,521	28,144
Asian/Pacific Islander	239,545	7,248
Native American	3,144	447
Other	288,421	18,601
Total	2,888,478	161,888

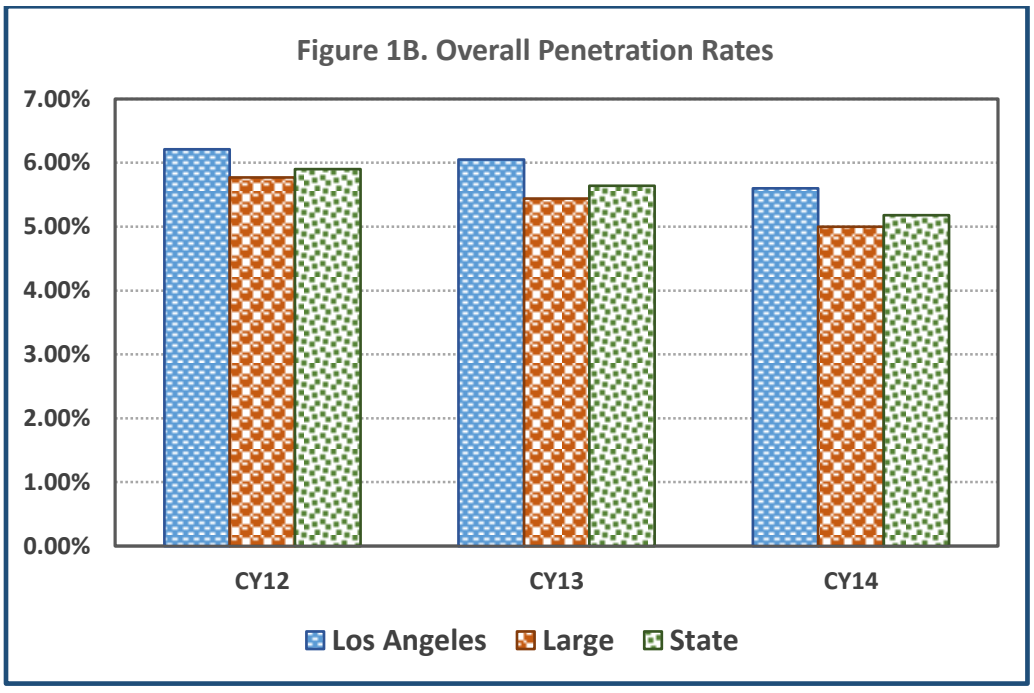
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

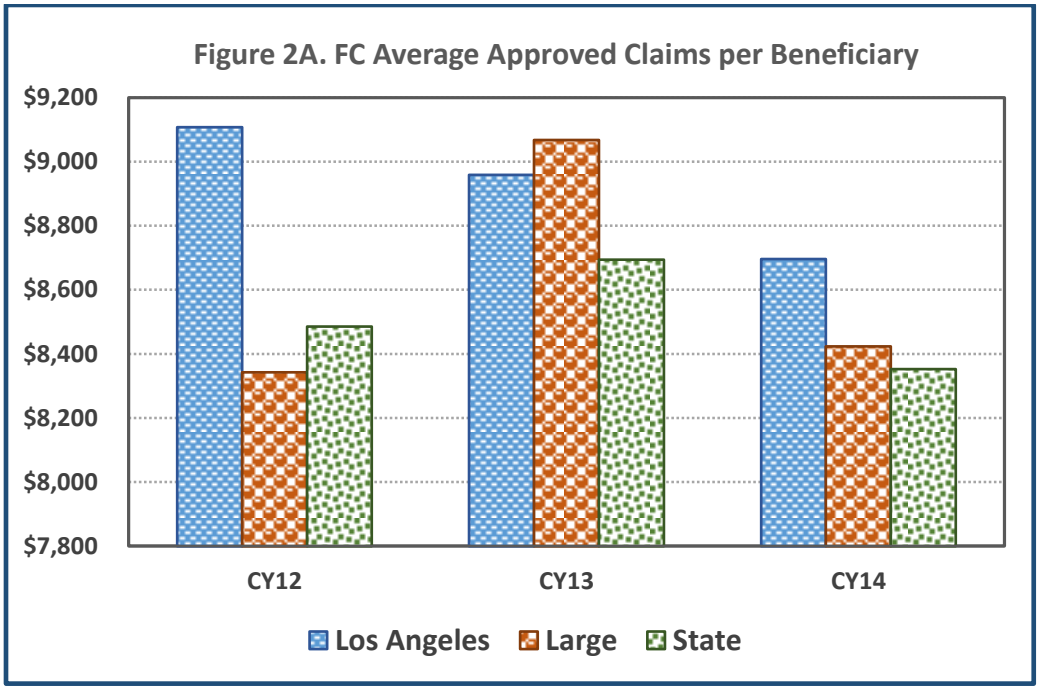
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

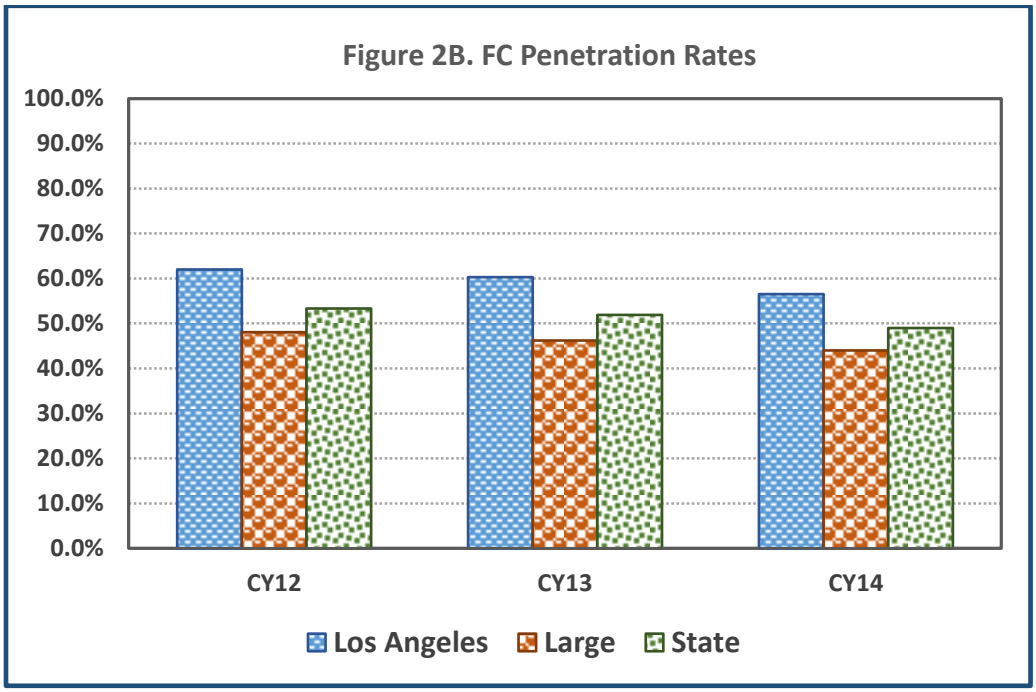
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



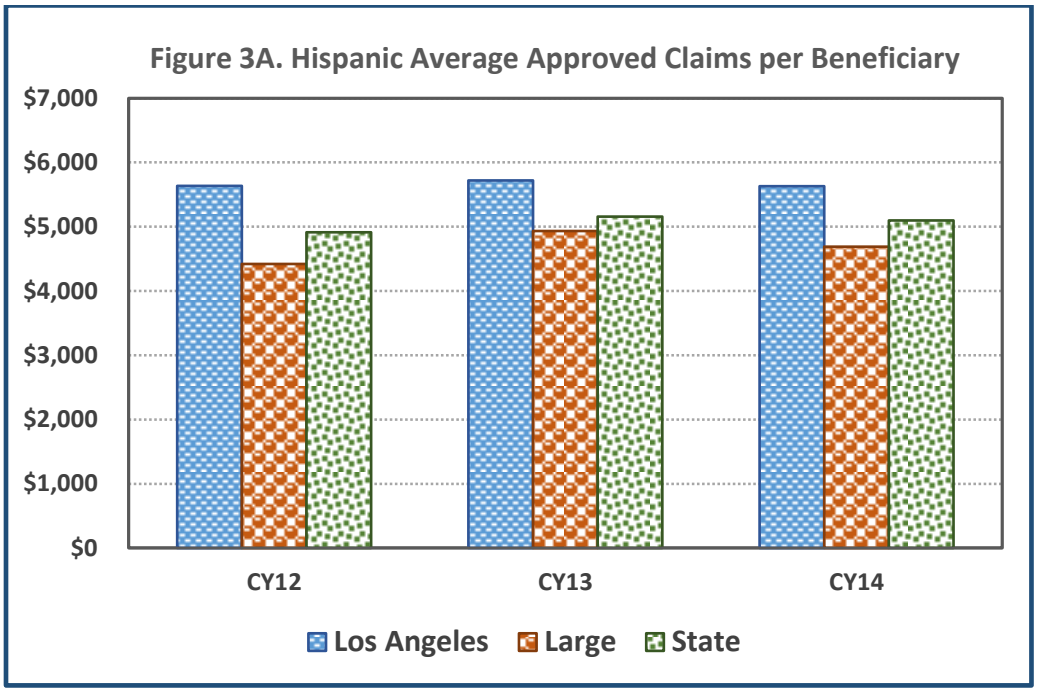


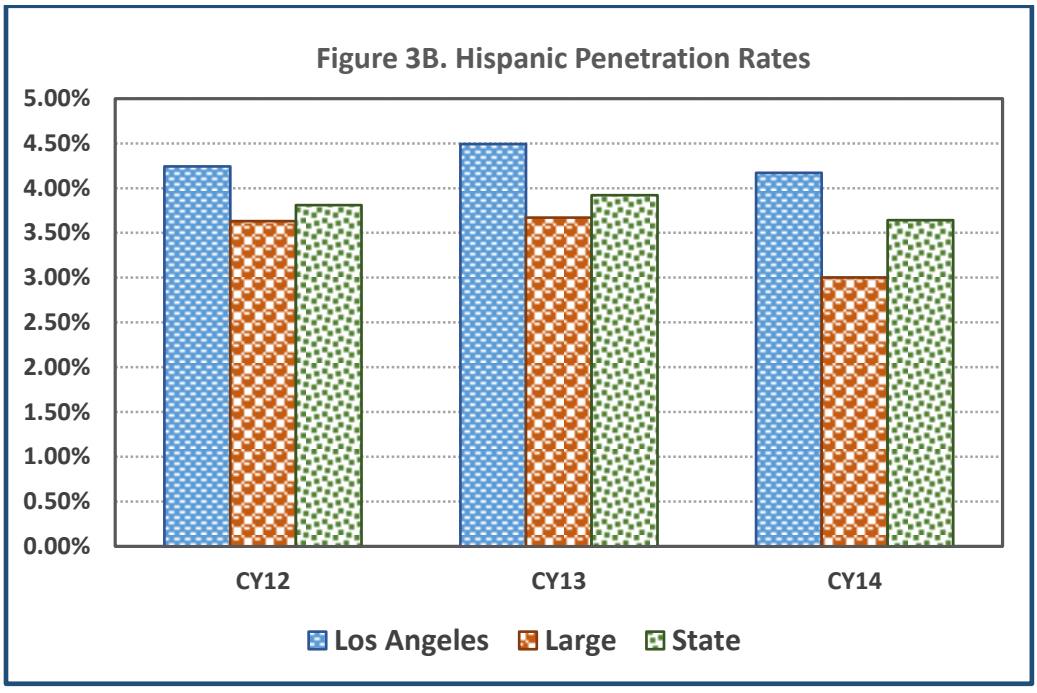
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for very Large MHPs.





Figures 3A and 3B show 3-year trends of the MHP's Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





HIGH-COST BENEFICIARIES

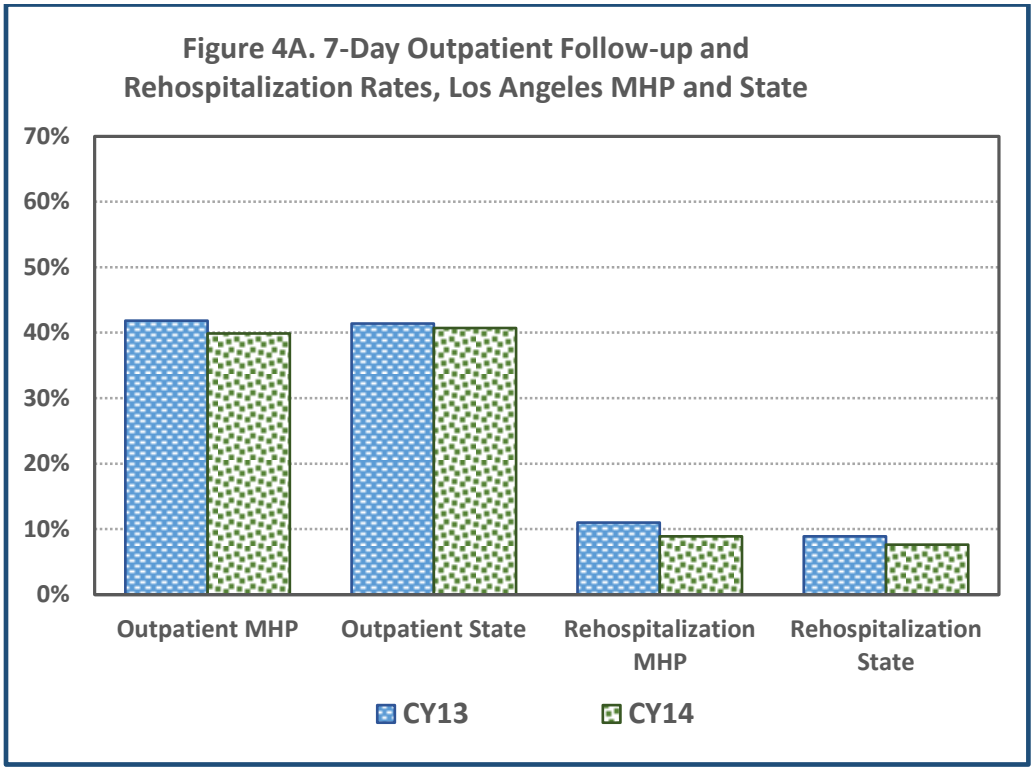
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

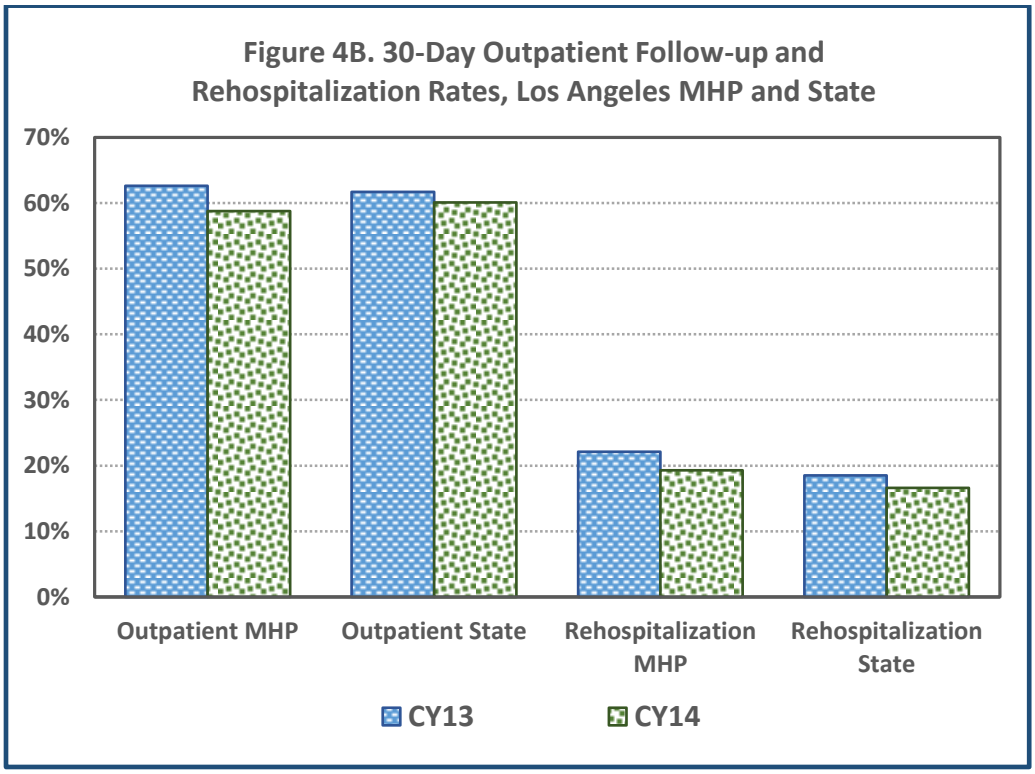
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Los Angeles	CY14	3,656	160,946	2.27%	$47,797	$174,744,257	20.08%
	CY13	4,353	160,258	2.72%	$49,104	$213,748,386	22.75%
	CY12	4,444	155,845	2.85%	$50,210	$223,134,187	24.59%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

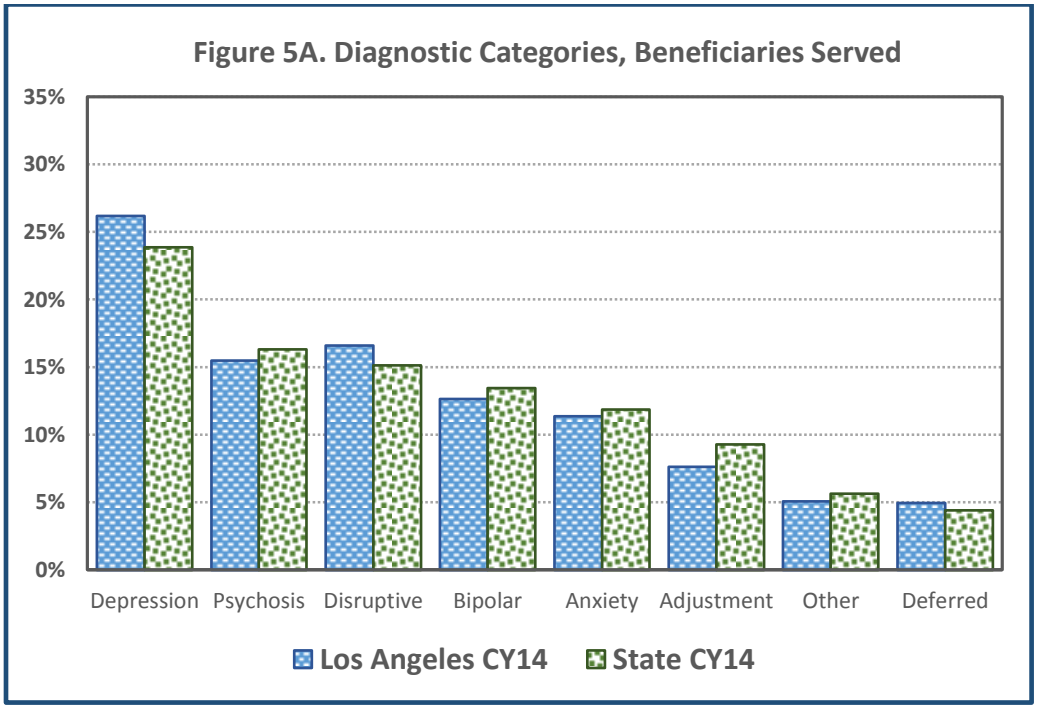
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY13 and CY14.

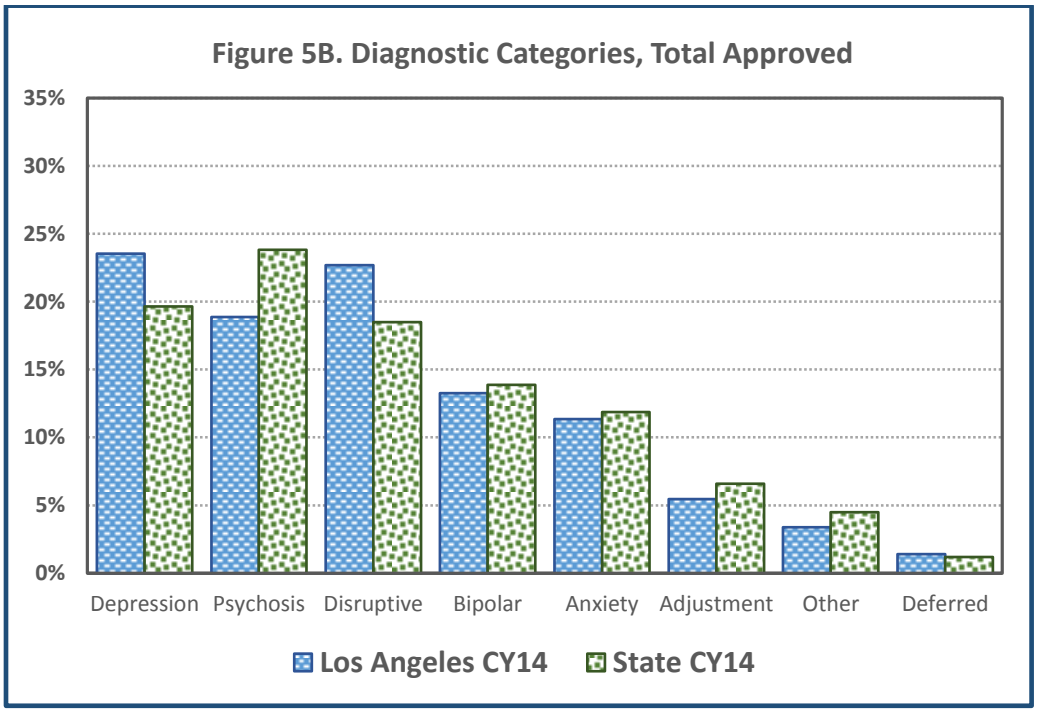




DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP penetration rate declined slightly during three-year period. However, its penetration rate was higher than both Large MHPs and statewide averages during the three-year period. (See Fig. 1B.)
  - The MHP Approved Claims per Beneficiary Served (ACBS) remain stable during the three-year period and was above Large MHPs and the statewide experience. (See Fig. 1A.)
  - The Foster Care penetration rate during the three-year period remain stable (56%-62%) and the trend was higher than both Large MHPs and the statewide averages. (See Fig. 2B.)
  - Foster Care ACBS remain stable during the three-year period and was similar to Large MHPs and the statewide experience. (See Fig. 2A.)
  - The MHP Hispanic beneficiary penetration rates continue to be slightly higher than the statewide experience; and Hispanic ACBS was higher than Large MHPs and the statewide experience during the three-year period. (See Figs. 3A&B.)
- Quality of Care
  - The MHP's percentage of High Cost Beneficiaries (HCB) declined in CY14 to 2.27%, which was slightly less than statewide experience at 2.48%. The MHP's

total percentage of approved claims for HCBs in CY14 at 20.08% was less than the statewide figure at 24.41%. (See Table 2.)

- Both HCB count and HCB total claim dollars have trended downward during the three-year period. (See Table 2.)
- While the MHP's use of Depression and Disruptive diagnoses is slightly higher than statewide figures, the claims dollars approved for these categories is higher than that of the statewide averages. (See Figs. 5A&5B.)
- The MHP's use of Psychosis diagnosis is within range of the statewide figure. The claims dollars approved for this category is lower than that of the statewide average. (See Figs. 5A&5B.)

- Consumer Outcomes
  - The MHP's 7-day and 30-day outpatient follow-up rates for CY14 are similar to its CY13 rates. (See Figs. 4A and 4B.)

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2014.

LOS ANGELES MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Los Angeles MHP submitted two PIP(s) for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	Commercial Sexual Exploitation of Children and Youth (CSECY)
Non-Clinical PIP	Vacancy Adjustment Notification System (VANS)

Table 3A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

Table 3A—PIP Validation Review					
				Item Rating*	
Step	PIP Section	Validation Item		Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	M	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	PM	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	M	M
		7.2	Interim data triggering modifications as needed	M	M

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		7.3	Data presented in adherence to the plan	M	M
		7.4	Initial and repeat measurements, statistical significance, threats to validity	PM	M
		7.5	Interpretation of results and follow-up	M	M
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	M	M
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	M	M
		8.3	Threats to comparability, internal and external validity	M	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	PM	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	M
		9.3	Improvement in performance linked to the PIP	M	M
		9.4	Statistical evidence of true improvement	M	M
		9.5	Sustained improvement demonstrated through repeated measures.	PM	M

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 3B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	26	30
Number Partially Met	4	0
Number Not Met	0	0

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Applicable (AP) (Maximum = 30)	0	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	93.3%	100%

CLINICAL PIP—COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN AND YOUTH (CSECY)

- The MHP presented its study question for the clinical PIP as follows:
  - "Will the CSECY training result in an increase in the number of CSECY consumers identified?
  - Will the CSECY training result in improved clinical outcomes for sampled CSECY victims receiving treatment from clinicians who completed the CSECY training compared to sampled CSECY victims treated previously by these clinicians prior to completing the CSECY training, as measured by:
    - ▷ The UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) and the Outcome Questionnaire (OQ) for CSECY consumers receiving trauma informed EBP services in outpatient settings
    - ▷ The Brief Symptom Inventory (BSI) for CSECY consumers served in Juvenile Halls
    - ▷ Full Service Partnership outcomes on the Outcomes Measures application
  - Will the CSECY training lead to increased clinician awareness of CSECY, increased awareness of mental health issues associated with CSECY and improve clinician confidence regarding ability to effectively identify and treat CSECY victims, as measured by the pre and post CSECY training surveys?"
- Date PIP began: July 2014
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

This is a continuation of the Clinical PIP the MHP submitted the prior review cycle. The focus of this PIP is to more completely identify the CSECY population, provide appropriate treatment and increase the skill set and confidence of the clinical staff in treatment of this vulnerable population. This study targets all beneficiaries, including, Medi-Cal beneficiaries within Child and Transition Age Youth (TAY) services who have been the victims of commercial sexual exploitation. In order to make significant strides towards changing the perceptions of the CSECY population and to enhance the process of providing effective and applicable interventions, the MHP identified training as essential. A two-pronged approach to training mental health practitioners was outlined by the MHP in order to:

- Increase awareness of the psychosocial factors pertaining to CSECY population (or "CSECY 101" training) so that CSECY victims are able to participate in a more comprehensive assessment and subsequently their treatment becomes geared towards addressing the psychosocial factors unique to their traumatic experiences.

- Provide clinical training on the best practices and trauma-informed mental health care that is specific to sexually exploited children and youth with a goal of improving the quality of services and outcomes for the CSECY identified population.

It is hoped that the suggested training series would better equip the mental health practitioner with the tools needed in order to identify, assess, and provide effective treatment services to CSECY. The indicators which the MHP identified to measure are:

- Study Measure 1: Identify the CSECY consumers from individuals that received CSECY training and who are actively serving CSECY consumers.

- Study Measure 2: Improved school attendance as measured by the FSP Outcomes Measures Application (OMA) for CSECY consumers treated by clinicians post-training compared to CSECY consumers treated by clinicians pre-training will demonstrate training's effectiveness. Scores on the PTSD-RI (adult or child form, depending on consumer's age) and YOQ or OQ (depending on consumer's age).

- Study Measure 3: Scores on the PTSD-RI (adult or child form, depending on consumer's age) and YOQ or OQ (depending on consumer's age).

- Study Measure 4: Clinical outcomes on the Global Severity Index (GSI) of the Brief Symptom Inventory for CSECY consumers treated by clinicians in Juvenile Halls post-training compared to CSECY consumers treated by clinicians pre-training will demonstrate training's effectiveness and reduction in distress level for CSECY consumers. Global Severity Index (GSI) on the Brief Symptom Inventory (BSI).

- Study Measure 5: Improved school attendance as measured by the FSP Outcomes Measures Application (OMA) for CSECY consumers treated by clinicians post-training

compared to CSECY consumers treated by clinicians pre-training will demonstrate training's effectiveness.

- Study Measure 6: Improved clinician awareness of CSECY, awareness of mental health issues associated with CSECY, and confidence in treating CSECY victims will contribute to improved beneficiary outcomes and satisfaction.

The scores from the outcome tools measure interpersonal relations, social problems, behavior dysfunctions, symptom distress, and mental health issues associated with sexual trauma.

The interventions are designed to collect the following data for the indicators:

- Pre and Post Survey Comparisons
- EBP outcomes for CSECY victims post-training
- Pre and Post Survey Comparisons
- Number of CSECY consumers identified.

In June of 2015, it was determined that a SharePoint site where directly-operated staff could identify and provide data on CSECY victims would simplify tracking. A SharePoint site is a secure website accessible through LACDMH's intranet. Subsequently, multiple trainings in using the SharePoint site were conducted for directly operated staff.

The training efforts of the CSECY PIP team span from increasing the number of trainings available, outreach efforts to CSECY serving clinicians, re-structuring the design and registration of the training, and exploring additional training needs.

Data was collected, reviewed and analyzed as indicated ongoing for all trainings and CSECY data collection methodology. Improvements were made on-going as HIPAA compliance issues emerged; pre and post surveys were revised regarding identification of the target populations; an improved method of data collection via SharePoint site was implemented. Results reported by the MHP on its indicators were submitted as follows:

- Study Measure 1--Client Identification: a total of 326 CSECY consumers were identified. Out of these, 167 consumers were identified as receiving services in Juvenile Halls, 56 were from Outpatient programs and 73 others (did not have a specific Client ID) were reported from Juvenile Court Mental Health Services.
    - For 223 consumers for whom Client ID information was available, data was analyzed for the Outcomes Measures. This list could be gathered only for consumers seen by clinicians post CSECY training.
- Study Measures 2,3, and 5—Pre training consumer data was not available secondary to multiple barriers in collecting consumer information and also the change in collecting this data was revised. Previous trainings collected it post training, a modification was made beginning in December 2015 to collect it pre-training.

- Study Measure 4--Clinical outcomes on the Global Severity Index (GSI): Out of the 167 consumers in the Juvenile Hall, only 27 consumers had a Pre Post GSI data reported. For 48% (n = 13) of these 27 consumers, there was a decline of an average of 11 points in their post score thereby indicating an improvement. The range for pre/baseline score was 33-77 and the range for post was 26-65 for this group. For three consumers the GSI score remained the same and for the remaining 11 consumers there was an increase in the post scores compared to the baseline. The range for pre/baseline score was 28-65 and the range for post was 35-80 for this group.
    - Of the 223 consumers with available Client IDs, 48 showed pre post matched pairs data available for EBP measures, 17 unique consumers were receiving services from FSP programs and 22 received services from FCCS. FSP and FCCS Outcomes data were provided during the April 25, 2016 Clinical PIP EQRO session.
- Study Measure 6--For the Spring 2015 surveys there were statistically significant pre post differences ($p < .001$) in the awareness of CSECY, in the awareness of mental health issues associated with CSECY, and the level of confidence in treating CSECY consumers (N = 105). For Study Measure 6, for the Fall 2015 surveys there were statistically significant pre post differences ($p < .001$) in the awareness of CSECY, in the awareness of mental health issues associated with CSECY, and level of confidence in treating CSECY consumers (N = 52).

Clinicians reporting on the post-training survey noted improvement in awareness of CSECY, awareness of mental health issues associated with CSECY, and confidence in treating CSECY victims when compared to their pre-training surveys.

Several follow up activities are planned including a broad based community training for Faith-based leaders, homeless shelters and drop in centers. An interdepartmental committee formed and developed a protocol to serve the CSECY population.

The use of appropriate outcome measures will be analyzed for use with this population. Due to the transient nature of this population, it was difficult to track and administer pre and post administrations when there were unplanned discharges. Monitoring of administration of the surveys can be improved.

The MHP provided an update for the data analysis and interpretation of the PIP document during the Clinical PIP EQRO session at the time of the site review.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of advising the MHP to continue its efforts with the intent of this PIP and to consider this PIP complete for purposes of submission for the next review cycle. The MHP was encouraged to identify the consumer progress and where necessary make improvements. The MHP was advised to continue to check via its survey with providers to determine the level of confidence of treatment modalities. It is advised

that the MHP would benefit from increased identification of the study group and apply interventions on-going for the vulnerable population and determine the most applicable outcome tool to measure consumer progress. It may determine the potential of community-wide participation in stigma reduction for this group with its interagency committee which was an offspring of this PIP.

Since the MHP will need to submit a new clinical PIP next review cycle, the MHP was reminded to consult with the CalEQRO staff to determine the study question, the indicators, the data collection and modifications as needed while in the initial phase to ensure meeting the PIP standards. The CalEQRO staff recommended the MHP identify a brief yet focused and measurable study question with indicators which benefit the consumer. The consumer benefits will need to be measured for progress, via a variety of methods such as the outcome tools, surveys, and relevant consumer participation. These will require standards for improvements based on the essential baseline data that drives the need for a PIP.

NON-CLINICAL PIP—VACANCY ADJUSTMENT NOTIFICATION SYSTEM

- The MHP presented its study question for the non-clinical PIP as follows:
    - "Will the continued implementation of VANS increase the number of referrals to consumers by providers using VANS in SAs 4, 5, 6 and 8 and thereby improve access to care?
    - Will updates of slot information by funding source such as for Medi-Cal versus Indigent by providers using VANS increase referrals to consumers and thereby increase their access to care?
    - Will the updates of slot information by language capacity by providers using VANS increase referrals and thereby improve access to care for Non-English speaking consumers in SAs 4, 5, 6 and 8?"
- Date PIP began: July 2013
- Status of PIP:

    ☐ Active and ongoing

    ☒ Completed

    ☐ Inactive, developed in a prior year

    ☐ Concept only, not yet active

    ☐ Submission determined not to be a PIP

☐ No PIP submitted

This is a continuation from the prior review cycle for the MHP of the non-clinical PIP in Service Area (SA) 4 and subsequent expansion of the rollout to SA 5, 6, and 8. The MHP submitted this PIP for a second review cycle which has been implemented in SA 4.

The concept of the VANS project began with Service Area (SA) 4 administration seeking a solution to obtain timely appointments for consumers and to fill vacant program slots for efficient service delivery and make appropriate referrals to other agencies when program slots are unavailable at their own agency. The study population includes all consumers who require an appointment and for this PIP specifically in SA 4, SA 5, SA 6, and SA 8.

This Performance Improvement Project focused on addressing the following barriers to access:

- System Level factors related to referral processes and communication and to practical factors related to the length of process to make an appointment.
- Focused on development of a technology tool for access to accurate information to vacancy slots by type of service, language, age group, and funding source named the "Vacancy Adjustment Notification System" (VANS).
- To improve access to care as the VANS provides timely information on the availability of services and helps in avoiding delays to receiving appropriate care.
- To offer information on physical accessibility of appropriate services leading to timely referrals to consumers.

The PIP study includes both process and outcome measures. The PIP objectives were to increase efficiency, improve quality of service, and reduce risk to consumers with timely appointments and referrals in real time. The indicators were focused on improving outcomes such as expedited referrals and expedited appointments focused on reducing symptom risk for consumers. Timely provision of follow-up service is also tracked and reported in a separate committee.

While the intention is to provide efficiencies in providing timely appointments, it appears the majority of these indicators address the providers use and imply benefit to consumers. Other benefits to consumers such as language availability and referral expediency measure the quality of these potential improved results.

Process measures:

- Number of providers issued VANS User IDs.
- Number of providers using VANS.
- Number of providers updating available slots by service and program type.
- Number of providers updating available slots for language capacity.
- Number of providers updating available slots by funding source.

Outcome Measures:

- Number of referrals made using VANS.
- Number of referrals from VANS with an appointment in the Service Request Tracking. System (SRTS)/Service Request Log (SRL).

Real time tracking was done, monthly reports were reviewed, and quarterly comparisons to review for improvements were completed as planned. Modifications were made on-going such as PDSA surveys, convening to integrate the SRTS and SRL applications. Results of the indicators include the following:

- Upon review of VANS Performance Indicators for the period of January 2015 (Q1) to December 2015 (Q4), the total number of referrals from providers using VANS increased from 16 to 60. This represents a 50% improvement between Q1 and Q4. The expected achievement was 20% or greater.
- The number of providers using VANS increased by 34% between January 2015 and December 2015, from 59% to 93%, respectively.
- The number of providers updating available slots by funding source on a monthly basis increased by 2% between January 2015 and December 2015, from 78% to 80%, respectively.
- The number of providers with additional language capacity besides English updating available slots increased by 7% between January 2015 and December 2015, from 78% to 85%, respectively.
- The VANS application also has information on language capacity of providers. Therefore it also helps providers in making appropriate referrals by language. Currently the referrals and availability of slots is available from providers with the following language capacity: Arabic, Cantonese, Ethiopian, English, Spanish, Farsi, Armenian, Japanese, Cambodian, Korean, Lao, Mandarin, Russian, Thai, Tagalog, Vietnamese and Other Chinese.

The study question results are favorable in terms of the increased use of the VANS by providers. There is limited improvement in the results for both the other question indicators which are: The update of the funding source slots and the provider language capacity (besides English). Since the increase is marginal, the MHP is encouraged to continue to apply modifications, as it has done with explaining the cause of the referral calculations which was attributed to provider's decision to call rather than electronically refer.

Future reports will track referral notification by intake agency's language capacity to see how many non-English referrals are being made using VANS.

Indications of the success of the PIP include:

- Although limited, the MHP did provide a consumer success story of the expedited referral process and the benefits and CalEQRO staff encouraged the MHP to do this on-going.
- Overall, the current PIP has expanded its scope to SA 5, SA 6 and SA 8 and also plans to track the outcome of the referrals made via VANS from data related to the scheduled appointments for these referrals via the SRTS/SRL.
- The providers in SA 4 and SA 5 who have been using VANS have found this to be a valuable tool for tracking accurate referral information on availability of slots by type of service, funding, and language and have reported that this has been helpful to improve access and timeliness to the consumers served.
- SA 6 and SA 8 are hopeful of similar outcomes with the usage of VANS in their SAs.

Follow up activities include:

- To ensure VANS-SRTS link is implemented in the upcoming months and to implement VANS in the remaining four Service Areas.
- Once all the SAs implement the VANS to update their slot information, ACCESS Center will be provided access to VANS to provide referrals to callers who call the LACDMH 24/7 hotline.
- Other follow up activities include developing reports for outcome measures to track the number of referrals from VANS that generated scheduled appointments in SRTS and further the number of appointments that resulted in clinical assessments and services.
- Continued enhancement of the VANS to serve the needs of the multiple users and to refine the filters to make this tool user friendly and useful to search for slots per the user's needs.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of encouraging the MHP to identify and increase provider utilization of the VANS for efficiencies to both the consumer and staff, to determine the number of referrals made using the VANS secondary to the MHP identifying that the staff inclination is to provide a warm-handoff via a direct phone call, and to broaden the evidence of consumer benefit and effectiveness such as it has begun to do with a sharing of a "success story" amongst staff.

It is determined with the progress that the MHP has made to improve this application, coupled with the roll out and expansion to other Service Areas and its effective use of modifications when indicated, that the MHP will include this as a formal business practice. This PIP is considered complete for purposes of ratings for the next year. It will need to submit a new PIP for the next review cycle and the recommendation to seek consultation as needed was made. The MHP will need to address its new PIP study question, identify indicators and consistently measure and review the

progress, with modifications as needed. The MHP will need to consider and measure the benefit or direct outcome which benefits the consumer. This can take the form of a standardized tool, a survey or other methodology as determined applicable. The MHP is encouraged to submit a brief yet focused and measurable study question. The MHP is reminded that the baseline data will provide the foundation which determines the extent of the issue identified for improvement.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Real-time appointments and referrals through VANS are linked to expedited access to services.
    - Immediate provision of services in a consumer's preferred language promotes engagement.
    - Early identification of high risk trauma related to sexual exploitation can promote symptom reduction.
- Timeliness of Services
    - Identification and treatment approaches for sexually exploited youth delivered earlier potentially lead to decreased symptoms.
    - The elimination of subsequent calls for appointments with the VANS system promotes timely care and potential early engagement.
    - The use of VANS provides improved timely access and timely referrals, eliminating multiple call backs or dropped calls.
- Quality of Care
    - Effectively addressing the needs of a high risk target population indicates quality care.
    - The expedited appointment and referral system in real time leads to earlier service provision and subsequent potential increased functioning.
    - Training providers and enhancing confidence in identifying vulnerable populations represents quality and pro-active care.
- Consumer Outcomes
    - The earlier the appropriate treatment is provided, the increased benefit to consumer recovery is likely.
    - Increased identification and subsequent adequate treatment for sexually exploited youth can lead to increased awareness and stigma reduction community wide.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management—an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs—are discussed below.

Access to Care

As shown in Table 4, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 4—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP tracks language preference by each SA, gender, ethnicity and age and includes geo-mapping of its services and satisfaction results. The MHP conducts analysis of unmet needs through penetration rate data, and trends analysis over a five year period. MHP is expanding trainings on the Core Practice Model and Child and Family Teaming to mental health providers and Child Welfare System consumers. Trainings emphasize the element of "family's voice and choice," and the family being viewed as the expert in the teaming process, while increasing cultural awareness and respect. In order to more fully address cultural issues of consumers, cultural and linguistic competence efforts have been redefined as Under-served Cultural Communities (UsCC), and reflects a broader focus on culture, including gender and sexual identity as well as other aspects. In an effort to enhance services to Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S) youth, the TAY System of Care (SOC) developed trainings, support groups, and community engagement to this target population and their families. The MHP contracted with four agencies to provide these services. A new initiative for the TAY SOC is Supported Employment: Independent Placement and Supports (SEIPS) which is an evidence-based practice developed at Dartmouth University. The program assists and supports people with obtaining and maintaining competitive employment in the community. The MHP initiated specialized services directed towards victims of

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			Commercial Sexual Exploitation of Children and Youth (CSECY) population, with staff trained in the assessment and treatment of these victims of sexual trafficking. Multiple stakeholder groups noted the value of including spirituality to treatment in conjunction with sensitivity to cultural norms, with MHP sponsored training events. New Beginnings, an engagement effort, is a group service provided following the initial access and assessment. Consumers meet four times with a clinician to engage in a treatment plan process. Some Spanish-speaking groups developed a bond and subsequently continued to meet. The Mobile Triage Teams (MTT) expanded in the Spring 2015. The MTTs target the homeless, veterans and/or older adult populations. The MTTs are directly operated with a team of 8 staff in each of the eight Service Areas. The MTTs provide field-based triage and assessment of individuals/families to determine eligibility for MH services and to actively link them to the appropriate on-going services. Stakeholder groups indicated the assessment process for housing acquisition (a regulated application form) is cumbersome and not sensitive to this populations needs.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP has co-located its staff within the Child Welfare Services (CWS) unit. Agency members of the Katie A. collaborative engaged in an approach, known as the Immersion Strategy, which calls for an intense focus on two geographic units initially, with the expectation to expand countywide, and to develop the mental health resources needed to integrate the Core Practice Model (CPM). Through the use of MHSA funds, the MHP continues to expand the availability of ICC and IHBS for Child Welfare System subclass members, adding capacity for approximately 1,500 additional children this year. MHP is a participant in the Statewide SB 785, Out of County Medi-Cal Program. Through that program, children who are either, Child Welfare dependents, post-adoptions, or a part of the Kinship Guardian Assistance program, and who live outside of their County of origin, are eligible to receive medically necessary specialty mental health services within their resident county with proper authorization from the host county. The departments also conduct weekly matching of mutually served consumers to track the services. An alert system has also been established bi-directionally to inform each of service delivery to provide care coordination and the sharing of information. A medical case worker was assigned to the specialized treatment units at Central Juvenile Hall in order more effectively link “First Break” youth and their families to services.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			Forensic Outreach Teams began in early 2016 with 14 contracted agencies. These teams assist those being released from jail with successful transitions to community based mental health treatment services. In an effort to enhance their ability to meet the 15-business day access to care requirement, several adult directly operated clinics have adopted the CARE Clinic model originally instituted at Long Beach Mental Health Center. The CARE Clinic is designed to integrate both health care screenings and mental health services within the client's treatment plan. It is a "one-stop" centralized process. The MHP was awarded $40,892,700 California Health Facilities Financing Authority (CHFFA) Funding to implement three psychiatric Urgent Care Centers (UCCs), 35 Crisis Residential Treatment Programs (CRTPs), and add 15 personnel for Mobile Crisis Support Teams. The move toward more field-based services for consumers is resulting in significant staff recruitment and retention issues, particularly with hiring culturally and linguistically competent staff.
1C	Integration and/or collaboration with community based services to improve access	FC	There are currently eight (8) Health Neighborhoods (HNs) in LA County, with additional HNs in various stages of development. HNs were developed to improve access to care, improve care coordination and contain cost through effective communication across providers sharing same client. Additionally, other community service and support providers participate to ensure that the full complement of services and supports are available to residents of a community. The MHP contracted with VIP Community Health Center to provide services. They serve children and youth (birth to 21 years old) who have been detained by the Department of Children and Family Services (DCFS) and are awaiting placement at the Child Welcome Center (CWC) or the Youth Welcome Center (YWC). VIP has hired 22 staff for their team. The MHP has entered into collaborative and integrated healthcare services with the Department of Health Services (DHS) by co-locating mental health staff at DHS's children's medical hub clinics. The staff are co-located at three medical hub clinics; Martin Luther King Outpatient Medical Center in Compton, High Desert Regional Medical Center in Lancaster and Olive View Medical Center in Sylmar. It will be co-locating staff at a fourth site, Harbor-UCLA Medical Center by June 30, 2016. The MHP implemented a pilot involving secure electronic transmission of referrals for primary care and referral responses via IBHIS CareConnect between its directly-operated San Fernando Mental Health Center and the contracted Tarzana Treatment Center. This transmission mechanism allows for the inclusion of appropriate clinical documents and data and serves as a prototype

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			for future referral and clinical data exchange processes between DMH directly operated programs and other health care entities. In June 2015, the MHP fully implemented the Assisted Outpatient Treatment (AOT)-Los Angeles (LA) program and expanded the number of seriously mentally ill individuals that could be served by adding 300 Full Service Partnership (FSP) slots and 60 Enriched Residential Services (ERS) beds. The VANS system establishes a way for contract organizational providers to share information about vacant slots, by specific need and target population, which may reduce time to service when providers lack capacity. Throughout the on-site review sessions the MHP demonstrated integration with contract and community services as well as ongoing integration and collaboration with the new blended Health Agency. The MHP demonstrated this with its efforts including but not limited to its Interfaith Clergy and Mental Health Roundtable; Community Collaborative Courts (CCC) Partnership, Homeless coalitions, Child Welfare Services partnerships, school based services, Veteran's Services, law enforcement agencies, Probation and Jail services and multiple ties with cultural and ethnic groups.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP set its standard for the length of time between initial contact and first appointment at 21 calendar days for directly operated clinics with IBHIS, captured data through the SRL, and met this overall at 88.33% of the time. For contract providers it is set at 15 business days, captured data through the SRTS, and met this overall at 70.34% of the time. The ACCESS Center 24/7 line which tracks referrals using SRTS, the standard is set at 15 business days and met this overall at 77.04% of the time.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	NC	The MHP does not track this indicator, although the MHP did present extensive policies regarding triage of presenting issues. This included emergent, expedited, immediate, and routine appointment criteria. Fields were added to the Service Request Log with regard to whether a client had an emergent medication need and, if so, whether a medication appointment was provided on the same date as the intake assessment (as per policy). This is a step toward tracking access to initial medication appointments, and the MHP anticipates future data submission regarding this metric.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP tracked the urgent request data from the ACCESS Appointment Line using IBHIS beginning June 2015 and met its seven day standard overall at 81.90%. The MHP tracked the urgent request data from the ACCESS Appointment Line for CY15 using SRTS and met its five day standard overall at 98.83% according to the MHP narrative provided. Ongoing improvements to this metric have been initiated by the MHP with standardized processes and by introducing a fourth shift to the ACCESS Call Center 24/7 schedule.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	The MHP reported only partial data for CY15 from directly operated sites on IBHIS. No CY15 data was available from Legal Entities.
2E	Tracks and trends data on rehospitalizations	FC	The MHP indicated a 30 day readmission rate goal of 26% for adults and 14% for children. The MHP indicated for FY14-15, its adult rate was 26.6% and its children's rate was 14.5%.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2F	Tracks and trends No Shows	PC	The MHP reported an overall average no-show rate for clinicians at 7.36% and for psychiatrists at 17.36%. No standard or goal was provided. The MHP reported current tracking of this pertains to directly operated staff. The MHP reported data from the IBHIS Scheduling Calendar which drives its billing system. Staff use of this varies and appears to warrant review of its procedures.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has infused quality data driven activities into the majority of its expansive network. The QI Division (QID) consists of multiple units which incorporate its initiatives along with stakeholders from various levels, including consumers. Its executive team and the QI leadership team is exemplary in endorsing continuous quality improvement efforts. The department Quality Improvement Council, including each SA representative meets monthly and each participates in the Service Area Advisory Committee (SAAC). The Directly Operated (DO) and Contract Providers co-chair a SA QIC meeting at least quarterly, but some SA's have meetings bi-monthly or monthly depending on the agreement among the SA QIC membership. An annual evaluation of the prior year's QI goals indicated of the 19 goals for CY15, 12 goals were met or exceeded the goal. A QI Work Plan for CY16 was provided. Evaluating the usefulness of establishing a QI set of agenda items to be used across its varied QIC meetings may enhance standardized reporting to inform stakeholders of the QID initiatives.
3B	Data are used to inform management and guide decisions	FC	All 136 Directly Operated sites are operational on IBHIS. This includes sites where MHP employees are co-located with DHS, DCFS, SB82 or Medical Hubs. Twelve Legal Entity (LE) Contract Providers currently submit claims to IBHIS. The target is 30 LEs operational on IBHIS by August 2016.The MHP anticipates Fee for Service (FFS) providers will be operational on IBHIS by June 2017. The MHP measures and monitors data elements through various lenses which includes Strategies for Total Accountability and Total Success (STATS) and dashboards. Consumer outcomes are collected through surveys, MORS, YOQ and other measures applicable to each EBP.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3C	Evidence of effective communication from MHP administration	FC	The efforts of the department to communicate with both directly operated and contract providers is well-documented. However, in both SA4 and SA6, barriers to service were noted such as the required photo identification and the complex assessment for homelessness, and the required Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) completion. Of equal importance, developing a rapid onboarding process for new hires was indicated. Staff concerns about safety issues exist secondary to the demographics of neighborhoods in which staff are either deployed or in getting to the work facility through certain regions. Consumers and family members in both SA 4 and SA 6 access the website, are kept apprised of information via flyers, through staff including the Wellness Outreach Workers(WOW); Service Area Advisory Committee(SAAC); National Alliance of Mental Illness(NAMI); Steering Committee; Mental Health Services Act (MHSA);and the Faith Based Collaborative meetings. SA 6 offers 88 personal computers for use by consumers and family members at 21 of its clinic locations which includes a robust website. The MHP prescribes to the SAMHSA wellness and recovery model, and uses recovery language in the Adult SOC and resiliency in the Children's SOC. There is a monthly Recovery on a Roll (ROAR) meeting with clinic managers, and recovery-oriented supervision. While the leadership indicated creating a more consumer-friendly environment in the clinics, many focus group participants reported that the receptionist staff is non-welcoming. Some examples include: disregard towards consumers, inadequate cultural/language skills, and staff often avoid eye contact while serving them. Consumers report standing in long lines waiting for service while staff appear preoccupied with other activities and customer care is felt to be non-existent nor is providing compassionate relief experienced. Clinical line staff from multiple contract providers report that communication with the Department of Children and Family Services (DCFS) for consumer follow-up is one-directional, a potential treatment barrier to serving mutual consumers.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	TAY Full Service Partnership (FSP) and Field Capable Clinical Services (FCCS) capacity was increased in Service Area 1 by 15 slots and 30 slots respectively including Permanent Supportive Housing Program. Contract provider line staff in SA4 endorse that they have bi-directional communication and have input to MHP in area of program planning. District Chiefs agreed that they are part of system planning as well as participate in key committees. Each Service Area has an Advisory Committee (SAAC) that meets monthly in their area. The SAAC serves as a local forum for community members (including consumers and family members) to provide ongoing input and feedback to the MHP regarding service delivery, needs and gaps in service specific to their area, uses of resources, and community concerns. The SAAC is co-facilitated by two community stakeholders. The Cultural Competency Committee (CCC) membership represents the perspectives of directly-operated and contracted providers; consumer groups; family members; peer, parent and family advocates; community-based organizations; and Mental Health Commission. The CCC provides input and recommendations on various departmental and state initiatives related to cultural competency. For example: The creation of the Health Agency and California Reducing Disparities Project (CRDP) Strategic Plan Draft. Consumer/family members report multiple venues for input.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP is working collaboratively with DHS and the Department of Children and Family Services (DCFS) by co-locating mental health clinicians at DHS' pediatric medical HUBs. Medical HUBS offer an integrated healthcare approach to youth at risk of or involved with the child welfare system with a multi-disciplinary team of DHS physicians and nurses, DCFS social workers, and MHP co-located clinicians who provide mental health triage, initial assessment, crisis intervention, and linkage to community mental health providers. The MHP met with contract providers and developed a final set of recommendations for improving access to care across the mental health system in three key areas: universal screening, tracking capacity, and appointment scheduling. Primary Care providers partner with mental health, substance abuse, public health and other services and support agencies in each Health Neighborhood to ensure their patients have the access to the full array of services and supports in the community. Child Welfare Services has made space for co-location of staff for therapeutic foster care services. Active law enforcement engagement with MH mobile crisis teams have expanded which improved teambuilding and partnership between forensics (jails, sheriff) and contract providers. Faith-based organizations are partnered with the MHP to enhance outreach to underserved populations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3F	Measures clinical and/or functional outcomes of beneficiaries served	PC	The MHP continues to utilize EBP related instruments that measure progress; however, it has not adopted any specific system-wide instruments for all consumers. Clinical line staff from multiple contract agencies expressed the need for the MHP to determine on-going EBP selections and to receive Training of Trainers in order to subsequently train their own staff on EBPs. The MHP allows 32 PEI approved EBPs to be utilized, with each provider selecting those practices that best fit their client population. Very few EBPs allow for Training the Trainer. The MHP has worked with the EBP developers to promote training of Trainers, and in some instances have been able to craft an agency-specific Training of Trainer component. The PHQ-9 and Columbia Risk Assessment are embedded in IBHIS. Co-located inside seven DHS outpatient sites across LA County, the DMH/DHS Collaboration Program provides short term mental health treatment to patients suffering from moderate depression and anxiety. Clients are referred by their DHS medical providers and the treatment team includes both the DMH clinician and the DHS primary care provider. Outcomes: Some of the Prevention and Early Intervention (PEI) Outcome Measure Application (OMA) Outcome Measures for the DMH/DHS Collaboration Program for FY14-15 are as follows: • In 64 reported cases where anxiety was the focus of treatment, clients achieved (on average) a 56% improvement in self-reported symptoms when comparing baseline and end of treatment score results using a GAD-7. This was achieved (on average) in 9 sessions. • In 124 reported cases where depression was the focus of treatment, clients achieved (on average) a 61% improvement in self-reported symptoms when comparing baseline and end of treatment score results using a PHQ 9. This was achieved (on average) in 9 sessions. • When it came to clients not completing their treatment cycle, the vast majority fell into one of the following three (3) categories: ○ 33% withdrew, ○ 31% the Program was no longer able to contact, and 24% had been transferred to a higher level of care.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	MHP administers the required state consumer perception survey twice yearly. It also has other satisfaction instruments in use across its system for both staff and consumers. Some of consumer surveys include TAY Supportive Housing Satisfaction, Juvenile Justice-Involved Youth, Older Adults and CalWORKS. These are routinely compared to previous data collected. Improvements are made as indicated, for example, the MHP is aware of the cumbersome permanent housing paperwork and the housing environments and plans to address both. Contract providers indicate they are not collecting any field based MHSIP data, with some agencies serving 80% in the field, this proves problematic.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The Office of Consumer and Family Affairs Director has bi-directional communication with the Mental Health Executive Management Team and acts as bridge to Consumer and Family Members. The Program Director for the Office of Consumer and Family Affairs (OCFA) is a consumer, reports to the Acting Chief Deputy Director/Program Support Bureau (PSB) Deputy Director, and is on the Executive Management Team. The OCFA is staffed by many members with lived experience. The MHP has the Wellness Outreach Workers (WOW) designation where recovering consumers are trained to become credentialed volunteers and peer advocate candidates. To date, over 450 WOW workers have been trained and approximately 100 are currently serving in this capacity throughout the system. This experience then makes consumers and family members eligible to become paid Mental Health Advocates, Community Workers and/or Senior Community Workers. The MHP continues to struggle with the county regulations for disclosure (federally protected right) in hiring practices for consumers with lived experience. The MHP is actively building bridges for consumer employment through their contract providers. Consumers are represented on the SA Quality Improvement Committees and the Service Area Advisory Committees. Consumer Employees reported that over the past year the understanding of the Peer and Partner program has experienced a shift in acceptance. In SA4, the Consumer Employee focus group reported a feeling of stigma from the staff. The MHP is currently in the process of expanding entry level peer employment with MHSA (Mental Health Services Act) WET (Wellness Education and Training) dollars with a: •Housing Navigation Specialist Training •Peer Shelter and Spiritual Specialist (Hope Valley Shelter) •Peer Court Navigation Specialist (may be called Justice Involved) •Generalist Peer Specialist Trainings (improvement of

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	SA 6 has a computer training program at Augustus F. Hawkins, in which multiple levels/classes of training are available to consumers including access to their personal health portal. This last element includes appointments and other information available. The MHP and its Contract Providers have consumer/family member staff in all SOCs. Consumer Employees note there is no career ladder or known way of being promoted within their hiring positions. Several consumers mentioned that they were made aware of opportunities to be involved in Wellness Centers early in their treatment protocol. Exodus Recovery Wellness Center brochures and monthly calendars available, with hours of operation and crisis line number listed at the top. Its hours of operation are Monday to Friday from 8 am-4:30 pm. The Wellness Center offers multiple activities and self-improvement groups. There is one Wellness Center in SA 4 that has a Clubhouse Setting and is peer run with an emphasis on Group Therapy and Recovery services. The center also provides Employment and Rehabilitative Services. The Figueroa Center is a Peer Run Wellness Center and is open to the public. Its hours of operation are 8 am-5 pm.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Health Neighborhoods are provider networks based in particular geographic areas that join together to meet the variety of service needs of the residents of those communities.
  - A concentrated overhaul within the ACCESS Call Center has resulted in more timely access, response, and appointments and includes staffing resources.

- This same centralized scheduling mechanism was implemented for referrals coming through the Department of Health Services' (DHS) e-Consult process.
- The e-Consult system for psychiatry potentially enhances treatment outcomes with mutual consumers by providing psychiatric resources to primary care.
- The VANS project endorses efficiencies in the referral process and supports expedited service acquisition.
- Most directly operated clinics prospectively block a designated number of intake slots each week in their site's IBHIS appointment scheduling calendar for use by ACCESS Call Center staff.
- The MHP deployed its Mobile Triage Teams (MTT) which began in Spring 2015. The MTTs target people who are homeless, veterans and/or older adults. The MTTs are directly operated and there is one team of 8 staff in each of the eight Service Areas. The MTTs provide field-based triage and assessment of individuals/families to determine eligibility for MHP services and for those that are eligible to actively link them to the appropriate on-going services.
- Extensive outreach efforts were conducted in CY 2015 by the six UsCC subcommittees - African/African-American (AAA), American Indian/Alaska Native (AI/AN), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME), Latino, and Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Two-Spirit (LGBTQI2-S). These included Community Mental Health Stigma Reduction Projects, Media Outreach Campaigns such as Radio and Television Talk Shows, and Clinical Mental Health Trainings for outreach specific to LGBTQI2-S. Examples of outcomes include the Samoan Outreach and Engagement Program in which 240 mental health education workshops targeting the Samoan community were conducted and 1,284 individuals were reached between August 1, 2016 and February 28, 2016.
- For the Armenian Media Project, per the Charter Communications report 41,337 homes in the Glendale/Burbank area and 64,103 homes in the San Gabriel Valley area viewed the Armenian Mental Health Talk Shows.

- Timeliness of Services
  - The Strategies for Total Accountability and Total Success (STATS) reports address the access and timeliness measures and these metrics are reviewed and shared by the Executive Management Team (EMT) with the District Chiefs and Program Heads at the STATS meetings.
  - The MHP intends to capture its metric for initial assessment by data for the first offered appointment which was not available for the entire period of this review so it was calculated by scheduled date of appointment.
  - The MHP instituted an improvement to the unused urgent care appointment slots by filling these with the DHS psychiatry e-Consult requests. Modifications to the data collection will distinguish the future use of these slots,

- In addition, the MHP imposed quality activities within the ACCESS Call Center with a one minute response time to answer the urgent appointment line and a quality assurance procedure for customer service standards.
- As part of its contractor's performance measurements, ambulance contractors must be deployed to a field call and available to transport within 45 minutes.
- Community stakeholder feedback indicated the further one is from central operations, the less awareness of timeliness standards. In some cases the line staff indicate general adherence of standards; however, some clinics accept some maintaining wait-lists. (SA 6).

- Quality of Care
  - Quality of care is spread throughout this massive system which exhibits inclusivity of consumer needs and supports.
  - The MHP is currently in negotiations with some EBP developers and trainers to provide more training opportunities for PEI providers.
  - The MHP has expended considerable time, energy and dedication to improving its efficiencies and incorporating these into its electronic record system for consistent data retrieval.
- Consumer Outcomes
  - The MHP has expanded its services and training across its system to improve its penetration rate for its Katie A. Subclass. The intention here is to accelerate and demonstrate progress in meeting its obligations.
  - The MHP has co-located staff within the Child Welfare Services unit to address this population.
  - Welcoming strategies appear to be diminished in regard to attitudes toward consumers and peer consumer employees.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted four 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups, which included the following participant demographics or criteria:

- A group of 8-10 adult beneficiaries receiving services within the past year, emphasizing preferred language of Spanish served by Service Area (SA) 4.
- A group of 8-10 adult caregivers/parents of youth beneficiaries receiving services within the past year, emphasizing the Asian/Pacific Islander population served by Service Area 4.
- A group of 8-10 adult beneficiaries receiving services within the past year, those consumers with preferred Spanish language, emphasizing the Hispanic/Latino population served by Service Area 6.
- A group of 8-10 adult caregivers/parents of youth beneficiaries receiving services within the past year, emphasizing the African American population served by Service Area 6.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This was a group of 10 adult beneficiaries receiving services within the past year, emphasizing preferred language of Spanish served by Service Area 4. It was held at the Downtown Mental Health Center at 529 S. Maple Avenue, Los Angeles. Four participants were monolingual Spanish speaking and the remaining group attendees were bi-lingual Spanish/English speakers. All engaged in interpreter services that were provided. Two participants entered services within the past year.

For the participants who entered services within the past year, the experience was described as follows:

- Access to services was efficient, with both participants who were referred from a CalWORKS program to MHP SA 4.
- The clinic gave each of them the emergency numbers for crisis during their first face-to-face meeting.

For participants in group the experience was described as follows:

- The majority of participants agreed they were given a variety of useful information from the MHP regarding all the services and resources available to them.
- None of the participants had experienced any barriers accessing treatment.
- All participants endorse having individual therapy, a psychiatrist for medications and group therapy.
- Five participants would like more frequent psychiatrist appointments – generally 90 days between appointments are given.
- Participants stated therapists also serve in the role of case manager for them.
- Participants agreed that the support groups offered were useful to them. Specifically noted were wellness groups and depression management groups.
- The majority of the participants endorsed that they had access by telephone or text to their therapist.
- All participants agreed each knew the process to change a provider if necessary. However, this can be delayed if a request for a Spanish-speaking provider is made, especially to change psychiatrist.
- All participants agreed that the new facility was an improvement – larger, more airy and light, kitchen for client use, and secure.
- All participants were aware of the Wellness Center and felt it was useful to have access to even though they did not all use it on a regular basis.
- The participants indicated each received fliers, heard from their therapist/case manager, and generally felt informed about what is going on within the MHP in regards to services available to them.
- All of the participants agreed that they felt the staff was interested in their recovery, was available to them and were respectful of them. This includes the psychiatrists, clinical and administrative staff as well as security team on site.
- Several participants stated that they had been asked in therapy group for ideas to improve services. All were aware of satisfaction surveys.
- All participants appreciated the discounted bus pass availability; otherwise no transportation barriers to accessing services were noted.

Recommendations arising from this group include:

- Decrease the time between appointments.

- Increase staffing ratios, add more clinical staff and specifically more psychiatrists.
- Enhance communication among peers in order to collaborate regarding scheduling community activities within the wellness center.

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		10
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	10
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 7 3
Preferred Languages	English Spanish Bilingual: Spanish/English Other(s) _____	1 7 2
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	 10
Gender	Male Female Transgender Other Decline to state	2 8

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This was a group of six adult parents/foster parents and/or caregivers of children beneficiaries receiving services within the past year, emphasizing preferred language of Korean served by Service Area 4. It was held at the Koreatown Youth and Community Center (KYCC) at 3727 W. 6th Street, Los Angeles. Four participants were monolingual Korean speaking and the other participants were bi-lingual Korean/English-speaking. All engaged in the interpreter services provided.

For participants whose children received services the experience was described as follows:

- Access was not an issue for any of the participants.
- The participants all voiced the services had helped them, and also wanted more frequency of sessions.
- The participants indicated their children receive services from therapists, psychiatrists, and some attend groups.
- All participants attend a parent support group through Asian Pacific Center and it is facilitated in Korean with literature in Hangul language.
- Case Management services are available to all of the participants and provided by the Regional Service Center.
- Participants have information in the event urgent or emergency situation is required. All are aware of the option of a 911 call and/or going to the local Emergency Room for assistance. Additionally, a Family Peer Partner is available to them also to help with this.
- All participants agreed that although they were given the information of how to change a provider when they first began services, this would be uncomfortable for them due to not wanting to cause the provider to "lose face".
- Transportation is not an issue for the participants, and there is even some pickup and drop off services available.
- All participants agree that each can receive services in Korean as needed, and that language is not a barrier to their treatment.
- Therapists inform them of updates or changes within the mental health system of the county. They report they are asked for ideas to improve services.

Recommendations arising from this group include:

- Increase cultural sensitivity and norms training.
- Increase support to parents/caregivers as needed.

- Schedule frequent therapists and psychiatrists appointments.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants*		**6**
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	 6
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 4 2
Preferred Languages	English Spanish Bilingual Other(s)--Korean	 6
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	 6
Gender	Male Female Transgender Other Decline to state	 6

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Korean

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

This was a group of ten Hispanic/Latino adult beneficiaries receiving services within the past year, eight of whom were monolingual or bilingual Spanish speakers, and two native English speakers served by Service Area 6. It was held at the Augustus F. Hawkins Center at 1720 E. 120th Street, Los Angeles.

For participants who entered and/or utilized services within the past year, the experience was described as

- Clinical staff are very friendly and welcoming, share our values and are culturally appropriate and responsive.
- All participants reported that the receptionist staff are disrespectful to consumers, do not have adequate language skills, and do not look at consumers while waiting on them. Consumers are left standing in long lines waiting for service while staff are texting or talking on their phones, and customer care is non-existent.
- Front desk staff frequently call consumers to change the date and time of their appointments, however when consumers show up at the new date/time, there is no record of their rescheduled appointments.
- The majority of participants would like to see their therapist and psychiatrist more often, but feel it is not an option due to insufficient staffing and high caseloads.
- When leaving messages for their therapists, there were mixed responses regarding how long they had to wait for a call back from same day to weeks to not at all.
- Several participants reported that their therapists and psychiatrists were changed frequently causing them to have to start over, which was very frustrating because they had no closure with each, and it continually interrupted their therapeutic process.
- While most feel that they are getting better, especially when they take their medication, a few feel that they are not getting better and that their medication makes them feel worse.
- Therapeutic services are available in Spanish, however some consumers were unable to reach a Spanish-speaking receptionist when calling to make or change an appointment.
- Consumers participate in groups, lead groups, and are part of their treatment and care team. They also report that when on their own they are able to use coping skills taught by their therapists. Most were not aware of wellness centers.
- Half of the participants reported having knowledge of and participating in SAAC meetings on a monthly basis.
- Transportation is not a problem for accessing services.

Recommendations arising from this group include:

- Services and resources that are successful need to be replicated in all clinics.
- The front desk/receptionist staff need to significantly improve their customer care behavior, and treat consumers with respect and be more responsive and timely.
- Consumers need to be educated on whom to contact for various issues, needs and complaints.

Table 7C displays demographic information for the participants in group 3:

Table 7C—Consumer/Family Member Focus Group 3

Category		Number
Total Number of Participants*		**10**
Number/Type of Participants	Consumer Only	10
	Consumer and Family Member	1
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	5
	Older Adult (60+)	5
Preferred Languages	English	8
	Spanish	2
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	0
	Hispanic/Latino	10
	African American/Black	0
	Asian American/Pacific Islander	0
	Native American	0
	Other(s)_____	0
Gender	Male	1
	Female	9
	Transgender	0
	Other	0
	Decline to state	0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 3: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 4

This was a culturally mixed group of six adult parents/foster and kinship parents of youth beneficiaries receiving services within the past year in Service Area 6.

For participants who entered services within the past year, the experience was described as follows:

- The staff are very supportive, helpful, resourceful and patient.
- The system can be frustrating and difficult to navigate when first entering it, and there is confusion between which staff, services and programs are from social services versus mental health, especially for foster parents.
- Initial services are available quickly for both therapy and medication, and clinicians come to the home and school for assessments and ongoing treatment of children.
- All participants agreed that their children were improving as a result of the care they are receiving.
- Consumers receive therapy weekly to monthly, and psychiatric care weekly to every three months depending on how stable. Additional services are available as needed, and parents/caregivers know who to call for assistance and urgent care.
- Parents and caregivers are receiving support, therapy and services, and additionally participate in support groups and learning activities.
- Parents and caregivers feel their children's cultural and linguistic needs are being met.
- Participants were not aware of NAMI, SAAC, or other options for participation in system planning, programs or feedback. Less than half have participated in a consumer satisfaction survey.

Recommendations arising from this group include:

- Need to significantly increase the number and variety of low and no-cost activities available for youth.
- Need to increase the foster and kinship parent monthly stipends received for providing care to foster children.
- Call parents/foster parents once or twice a year to find out how things are going and if we need anything.
- Replicate successful initiatives from one clinic and/or Service Area to others, such as the monthly Family Night at Tessie Cleveland Community Services Corp.

- Increase information and support for youth who are aging-out of the children's system.

Table 7D displays demographic information for the participants in group 4:

Table 7D—Consumer/Family Member Focus Group 4		
Category		Number
Total Number of Participants*		**6**
Number/Type of Participants	Consumer Only	0
	Consumer and Family Member	1
	Family Member	5
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	3
	Older Adult (60+)	3
Preferred Languages	English	6
	Spanish	0
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	0
	Hispanic/Latino	1
	African American/Black	5
	Asian American/Pacific Islander	0
	Native American	0
	Other(s)_____	0
Gender	Male	1
	Female	5
	Transgender	0
	Other	0
	Decline to state	0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 4: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - The majority of participants would like to see their therapist and psychiatrist more often, but feel it is not an option due to insufficient staffing and high caseloads.
  - Consumers expressed that initial access to care is largely efficient.
- Timeliness of Services
  - Overall, timeliness was seen as efficient without undue barriers to service.
- Quality of Care
  - Overall, participants felt services were provided in the culturally linguistically preferred choice.
  - Many participants reported that the receptionist staff are disrespectful to consumers, do not have adequate language skills, and do not look at consumers while waiting on them. Consumers are left standing in long lines waiting for service and customer care is perceived as non-existent.
- Consumer Outcomes
  - Most felt that they are getting better, especially when they take their medication.
  - Consumers participate in groups, lead groups, and are part of their treatment and care team.

INFORMATION SYSTEMS REVIEW

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

KEY ISCA INFORMATION PROVIDED BY THE MHP

The following information is self-reported by the MHP in the ISCA and/or the site review.

Table 8 shows the percentage of services provided by type of service provider:

Table 8—Distribution of Services by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	22%
Contract providers	75%
Network providers	3%
Total	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☐ More than 1x month ☒ Weekly ☐ More than 1x weekly

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses:

20%

- MHP self-reported average monthly percent of missed appointments:

11.5%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

The following should be noted with regard to the above information:

- The MHP is aware that co-occurring diagnosis data underrepresents actual occurrence. They expect co-occurring diagnosis data to improve with the ongoing use of Integrated Behavioral Health Information System (IBHIS).
- The MHP is now able to track missed appointments through IBHIS for directly-operated clinics.
- For penetration rate calculations the MHP defines numerator/denominator as follows:
    - Numerator: Unduplicated number of consumers served in outpatient Short-Doyle Medi-Cal (SDMC) facilities who are at or below 138% Federal Poverty Level (FPL).

  - Denominator: County population estimated with SED and SMI diagnoses at or below 138% FPL (Prevalence).

- For prevalence calculations the data sources include: (1) California Health Interview Survey (CHIS for Prevalence), (2) LACDMH IS and IBHIS for consumers served in outpatient SDMC facilities, (3) American Community Survey, US Census Bureau for population estimates.

CURRENT OPERATIONS

- Final System Acceptance of Integrated Behavioral Health Information System (IBHIS) with Netsmart Technologies was achieved during December 2015. Currently 136 directly-operated sites are operational on IBHIS. This include sites where MHP staff are co-located with DHS, DCFS, SB82 or Medical HUB's. IBHS fully supports EHR functionality and SDMC billing and other State reporting requirements.

- As of April 2016, 12 Legal Entities (LE) are now operational on IBHIS.

- Approximately 120 LE's and all Fee-for-Services (FFS) providers currently continue to use Integrated System (IS). Which has been operational for the past 10 years and supports Practice Management and SDMC billing and other State reporting. Sierra Systems US, Inc., the vendor for IS, continues to fully support its operations. The IS legacy system is being replaced by IBHIS for all LE's and FFS providers.

- The MHP continues to expand the use of tele-psychiatry and the tele-mental health network. They continue to support about 33 different languages through the tele-mental health network. During the last year they served about 900 adults and 30 children and youth.

- Four contract providers also provide tele-psychiatry services: DiDi Hirsch, El Dorado, Hathaway Sycamore, and Pacific Clinics. They served about 100 clients during past year.

- San Fernando Mental Health Center, directly-operated site, has exchanged referral and clinical information with Tarzana Treatment Center (primary care site) since September 2015. The MHP is in discussions with other primary care providers who may be interested to exchange data to improve care coordination.

- Chief Information Office Bureau (CIOB) is responsible for MHP technology support and operations, is allocated 192 full-time equivalent items (positions). Since the previous CalEQRO review CIOB hired 17 new staff members and 21 staff have either retired, transferred, or terminated employment. Currently there are 34 unfilled positions.

MAJOR CHANGES SINCE LAST YEAR

- Integrated Behavioral Health Information System (IBHIS) implementation remains an ongoing multi-year activity with a number of sub-projects. The following lists significant initiatives that were completed or began during the past year:
    - Complete IBHIS rollout to remaining directly-operated sites.
    - Implement Netsmart Technologies contract amendment deliverables to improve the capability to produce a high-volume of "clean claims" both timely and efficiently.
    - Current projection is to have a total of thirty (30) LE's operational on IBHIS by September 2016. As of April 2016, twelve (12) are live.
    - Provide ongoing technical assistance to LE's and EHR vendors who have not yet achieved "IBHIS Go-Live Readiness" status.
    - Improvements to Practitioner Registration Maintenance (PRM) to allow real-time integration with both - IBHIS and CMS National Plan and Provider Enumeration System (NPPES).
    - Initial scan and indexing of active (open) client paper Medical Records into IBHIS for directly-operated sites completed.
    - Enhance Web Services functionality to improve the quality of client data (including diagnosis) coming into IBHIS from LE's local EHR systems. Provides a seamless mechanism for two-way exchange of relevant data between EHR systems without human intervention.
    - Expand the use of Service Request Tracking System (SRTS) to include LE's. To log and track timelines of initial request for services to produce state and federal timeliness data for dashboard reporting.
    - Implement IBHIS Data Integration and Provisioning for LE's and Fee for Services network providers.
    - Implement My Health Pointe – provides clients access to personal health record information. Currently in limited production use at most MHP directly operated sites.
    - Client View 1.0 is a pilot program at several co-located or non-MHP sites that enables clinicians to view IBHIS information about clients they are serving. Netsmart Technologies, the IBHIS vendor, has made Client View part of their product offering based on the MHP pilot.
- Contract Provider Technological Needs Project (CPTNP) remains a multi-year initiative. As the MHP prepares to rollout IBHIS for approximately 120 LE's over the next 12 to 18 months. Steps to ensure successful rollouts were developed and communicated to LE's and EHR vendors that include:

  - Dedicated Provider Advocate Office support for IBHIS providers.
  - Support Representatives assigned to help through IBHIS go-live preparation and post go-live transition.
  - Simplified process for Financial Eligibility.
  - Web Services go-live event at least two weeks prior to claims go-live.
  - Separate claims go-live event.
  - Orientation to IBHIS Reports for claims reconciliation.
- Department of Mental Health (DMH) Data Warehouse Re-Design
  - Implementation of IBHIS resulted in new clinical, administrative, and financial data being loaded into Data Warehouses on a daily basis.
  - Business Intelligence Roadmap Requirements and Strategy Document was developed, along with a high-level Conceptual Data Model.
- DMH Data Warehouse Load Project
  - Integrate IBHIS data with IS data into DMH Data Warehouse for reporting and data analyses purposed to Department Program Staff, State Reporting, County Auditors, Contract Providers, and other compliance data requests.
  - IS client, episode, legal entity, billing provider, service location, and rendering provider data were integrated with IBHIS data to support the Outcomes Measures application.
- Support for ICD-10 diagnosis implementation.
- Replace the legacy ACCESS Call Center Management application (ACCM) with IBHIS Incident Reporting module. Old application was decommissioned.
- Integration of Information Security Awareness training into New Hire onboarding.
- Implement Continuity of Care Document (CCD). HL7 standard electronic document used to exchange healthcare-related data with Primary Care facilities or other mental health service providers.
- Implement RSA Adaptive Authentication Pilot complete. To replace Hardware tokens for user's network access. It is an authentication and fraud detection platform that supports organizational defined rules for user security and access.
- Migrated email services to County Microsoft Office 365.
- Implement tele-psychiatry services complete.
- STAR Compliance Window Pre-IBHIS analysis complete.
- WinMagic Desktop Encryption was fully deployed.

PRIORITIES FOR THE COMING YEAR

- Integrated Behavioral Health Information System (IBHIS) project implementation priorities include:
  - DMH Practitioner Web Services
  - IBHIS Infrastructure upgrade
  - IBHIS Integration Infrastructure expansion
  - IS Push update
  - Ongoing Legal Entity Readiness and Onboarding support
  - Implement IBHIS for remaining LE's – which is approximately 120.
  - Evaluate whether County Jail and Probation sites will use IBHIS or continue to use the Cerner systems and pass needed data to IBHIS through some form of integration (the most likely scenario).
- Implement Biz Talk Interface Engine Upgrade.
- Implement Access to Care Data Program:
  - Service Request Tracking System (SRTS) Access to Care
  - Service Request Log (SRL).
- Implement Homeless Reporting.
- Transition from HITRUST to County Mandated Risk Management Framework.
- Support County Wide Master Data Management (CWMDM) System – Department of Mental Health implementation and integration with the County MDM.
- Continue to support Meaningful Use Incentive Program, Stage 2 activities.
- DMH Desktop and Mobile support and improvements:
  - Migrate to County Centralized Microsoft Office 365, Phase II
  - Mobile Device Management Solution
  - Windows 10 Upgrade.
- Continue support of Pharmacy Benefit Management Services Integration.
- Support Personal Health Record Awareness and Education, Phase II.
- Support Transitional Age Youth Program.

OTHER SIGNIFICANT ISSUES

- During January 2016 DMH reduced the active project list to 18-20 critical projects. Other projects were either deferred or terminated. As a result Chief Information Office Bureau (CIOB) reviewed employee assignments and those who were assigned to deferred or terminated projects are being reassigned to one of the 18-20 critical projects. Legal Entity (LE) readiness and onboarding to Integrated Behavioral Health Information System (IBHIS) is on the short list of critical projects and received the majority of the transferred resources.
- CIOB currently supports two mission-critical systems - IBHIS and Integrated Systems (IS) for the next 18 months or so. As IBHIS rollout to LE's approaches a tipping-point retention of subject matter expert technology and billing staff are critical while both systems produce revenue and support state-reporting requirements.
- CIOB Help Desk lacks sufficient staff resources to provide timely response for some Work Orders. A number of interviewed key informants reported timely response for non-expedited Work Orders (WOs) can extend to days, with the upper range being weeks before the WOs are resolved.
- During February 2016, US Department of Health and Human Services, Office of Inspector General (OIG) started an audit that is currently in progress for 55 Legal Entities and two Fee-for-Service providers.

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
IBHIS	CalPM, Child Welfare Services, MSO, Billing, Order Connect, Provider Connect, Care Connect, My Health Pointe	Netsmart Technologies	2	Vendor IS/CIOB
Integrated Systems	Practice Management, Billing	Sierra Systems US, Inc.	11	Vendor IS/CIOB
DMH Data Warehouse	Data Cubes for Reporting Purposes	CIOB	11	CIOB
BizTalk Integration Engine	Data Integration	Microsoft	4	CIOB

Table 9—Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
PATS	Pharmacy Adjudication and Tracking System	County ISD	22	County ISD

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace the current EHR system. New system in place.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 10—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments	Avatar	X			
Clinical decision support	Avatar	X			
Document imaging	Avatar	X			
Electronic signature—client	Avatar	X			
Electronic signature—provider	Avatar	X			
Laboratory results (eLab)	OrderConnect	X			
Outcomes	Avatar	X			
Prescriptions (eRx)	OrderConnect	X			
Progress notes	Avatar	X			
Treatment plans	Avatar	X			
Summary Totals for EHR Functionality		10	0	0	0

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Table 10 scoring is based on IBHIS/EHR implementation only for directly operated sites who are authorized to provide SDMC services.
- Legal Entities (LE) are required to implement local EHR systems and use EDI transactions to exchange data between their local systems and IBHIS. Onboarding of

LE's remains an ongoing activity which is currently planned to be complete by May 2017.

- Fee-for-Services (FFS) providers' readiness and onboarding activities are under development. Current plans are to have FFS providers exchange data between their local systems or clearing houses with IBHIS; scheduled to be complete by August 2017.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
    - Universal Screening uses a standardized process to evaluate whether an individual should receive an access to care initial clinical appointment. The same set of questions and data elements are currently, or will be, recorded in either Service Request Log (SRL) for directly operated sites or Service Request Tracking System (SRTS) application for contract providers.
    - Capacity tracking in pilot phase for Service Areas 4 and SA 5. Uses Vacancy Adjustment and Notification System (VANS) to track and share real-time program capacity information. Further enhancements include adding VANS link to SRTS so staff can quickly determine the best site to send a request for timely access to service.
    - VANS will be rolled out to additional Services Areas and the ACCESS Call Center in several phases with countywide deployment anticipated by summer 2016.
    - The use of tele-psychiatry services by the MHP to serve consumers who live in remote Service Areas continues to expand; and there are now four contract providers who provide tele-mental health services.
    - Tele-mental health services pilot project will track services for LA Care consumers with mild to moderate mental health diagnoses who are elderly or transportation challenged. Case managers are onsite with consumers and use laptop network for connectivity with psychiatrist.
- Timeliness of Services
    - Both SRTS and SRL applications provide the electronic "anchor date" for client's request for appointment or service referral, and will be used to accurately measure timeliness from initial service request to the first service provided.
    - Electronic referral to primary care – a pilot program. In September 2015, San Fernando Mental Health, directly operated site, and Tarzana Treatment Center (primary care site) began to securely exchange clinical documents and data.
- Quality of Care

- Expansion of CARE Clinic Model. CARE Clinic is designed to integrate both health care screenings and mental health services with a client's treatment plan. The goals of the CARE Clinic model are to:
  - Provide mental health treatment and basic physical health screenings for new and continuing clients who receive psychiatric medications.
  - Ensure client medical records fulfill county, state, and federal requirements, including Medi-Cal standards.
  - Improve bi-directional care between primary care providers and mental health programs, including the care need of clients with co-occurring disorders.

- Consumer Outcomes
  - The MHP's measurements of consumer outcomes is largely restricted to MHSA Full Service Partnership (FSP) requirements and other reporting needs and instruments associated with Evidence Based Practices (EBP). The opportunity to use scales to help guide treatment tracks would benefit the MHP and its consumers basing services provided on data findings.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- There were no barriers to preparing or conducting this review.

CONCLUSIONS

During the FY15-16 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
    - The MHP plans to implement a universal screening tool is used at all points of entry which includes directly operated sites, Legal Entity (LE) sites, and ACCESS Call Center. All sites are required to use the same set of questions for all new service requests to ensure a process that is consistent across the system.
    - The MHP's electronic Service Request Log (SRL) and Service Request Tracking System (SRTS) applications, along with Vacancy Adjustment Notification System (VANS) will improve the awareness of capacity and improve access for consumers.
    - The development of Health Neighborhoods shows promise to serve those reluctant to seek mental health care due to stigma, and also provides the opportunity for the less severely ill to have care incorporated in a one stop shop. Staff report clinics serving Health Neighborhoods could absorb the care of lower risk level individuals with specialty mental health consultation available as needed to reduce caseloads.
    - With the added fourth shift, from 9:30 am to 6 pm, the ACCESS Call Center capacity to respond to timely crisis calls has improved.

- The MHP continues to add performance measures with contract providers, for example, its ambulance response time indicates decreasing it to no more than 45 minutes response for all Service Areas.
- Strategies in SA 6 at Augustus F. Hawkins have overcome barriers to initial access and not only reduced time to initial assessment, but have seen improved access to psychiatry and reduction of no-shows for follow-up appointments. Staff back fill any cancellations or accept walk-ins. While not new, these innovations can improve the utilization of available staff time, and should be shared with other programs.
- Telepsychiatry supports remote area staff coverage issues with solutions that improve continuity of services, preferred over locum tenens providers. Telepsychiatry is being used as a solution to these areas in which the vacant psychiatry positions may be difficult to fill (SA 6).
- Workflows are currently being developed to utilize the MHP's Tele-mental Health Network in order to provide linguistically and culturally matched care to clients requesting services in certain threshold languages.
- In addition, the tele-mental health unit will provide consultation for primary care practitioners who were previously limited to either direct referrals to specialty care or treating on their own.

- Opportunities:
  - Consider support to providers to develop an ongoing training calendar for EBP's which each provider intends to continue to use in order to facilitate prioritizing on-going training for staff delivering these services.
  - Until IBHIS is operational for all providers and practitioners, the CIOB unit will need to consider its support to both IS and IBHIS. Both systems are mission-critical during the next 12 months for overall success to serve individuals timely and adequately.
  - For a number of years both the DMH Human Resources and the CIOB Help Desk have been understaffed. This lack of additional resources has impacted key support functions for the department and this timely attention is critical to its success.

Timeliness of Services

- Strengths:
  - In SA6 initial access timeliness was reportedly improved by some programs due to innovations that emphasize same-day intakes, exceeding the MHP's standard significantly.
  - The Service Request Logs (SRL) are entered into IBHIS which contributes to access and timeliness and includes all clinic providers. Staff can now use SRL or

SRTS applications to schedule appointments for new consumers for use in real-time.

- Opportunities:
    - The MHP will benefit from increased efforts to track and report metrics for psychiatry assessment appointments to inform it of meeting its timeliness standards.

Quality of Care

- Strengths:
    - IBHIS provides meaningful access information for consumers served in directly operated programs. In addition to routine treatment functions, IBHIS also provides much needed information to the Psychiatric Mobile Response Team (PMRT) members who respond to field crisis calls.
    - Service Request Log (SRL) provides information about timeliness with data/reporting routinely run, and with information incorporated into STATS.
    - IBHIS provides numerous reports that enable supervisors and managers to monitor service delivery and compliance with quality requirements, such as documentation timeliness, attestation timeliness, and existence of a current treatment plan. Super-users and supervisors engage in a monthly webinar for training updates for use of IBHIS, rolling out the information to users within a 24 hour timeline.
    - While attempts to create a more consumer-friendly environment in the clinics, many focus group participants reported that the receptionist staff may disregard consumers, do not have adequate second language skills, and do not establish eye contact when greeting. Consumers may be left standing in long lines waiting for service while staff is pre-occupied, leaving consumers feeling customer care is non-existent.
- Opportunities:
    - The MHP continues to expand its focus on performance standards with contractors. It is working with contractors to create benchmarks which are normative across the department.
    - Both directly operated sites and contract providers would benefit from support in developing an adequate training schedule for staff in the EBPs each implements, especially in consideration of staffing changes.
    - Safety is a challenge for those doing home visits in neighborhoods with known gang activity or SMI homeless populations, and when daylight hours are minimal. On-going or additional training may impact security efforts as well as implementing a “buddy system”.

- High staff turnover for both contractors and directly operated sites presents challenges to continuity of care and maintenance of adequate staffing capacity in most Service Areas. Whether staff vacate to better paying entities such as the health plans or to reassignment to more desirable locations, stability of clinical staff, and sustaining the work force level are key to providing quality care. Study of the related issues – including efforts to achieve salary and benefit parity, as well as expediting the hiring process timeline for directly operated programs -- would likely improve efficiency of services and outcomes for consumers.
- Sufficient staffing resources from the CIOB Help Desk is critical in order to respond timely to Work Orders given the two mission-critical projects it will support.
- The MHP could review the usefulness of a set of standardized agenda items to be included in each Service Area QIC meeting which covers the current quality improvement activities such as the PIPs, timeliness and new service delivery strategies. This could provide consistent reporting and transparency efforts that reaches beyond compliance for all SA.
- Now that STATS information is uniformly shared across Service Areas and QID staff, further monitoring should be maintained to ensure standardized use of the STATS data for their intended purposes.

Consumer Outcomes

- Strengths:
  - Improvements towards inclusivity is noted with the cultural competency activities name change from Under-Represented Ethnic Populations (UREP) to Under-served Cultural Communities (UsCC).

    SA6 provides computer training for consumers, incorporated in a three-level training program, which includes assisting consumers to access their health portal in IBHIS (My Health Pointe). Consumers are able to access information about appointments among other health-related information.
- Opportunities:
  - Consider revising the New Hire Orientation to include the roles that Peer and Family Partners bring to the service delivery to ensure recognizing and valuing peer employees by staff. Consumer employees expressed it would be helpful to explain their jobs, the reasons they are there, and how they integrally fit into the system of care.
  - Staff indicated safety is a challenge for those doing home visits in neighborhoods and when walking to their cars past daylight hours.

- Consider the development of a process that identifies early barriers to service delivery, assigning a leadership champion who will ensue the issues are resolved (examples include the required photo ID problem and the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) application for homeless individuals).
- The MHP's adoption of level of care and/or universal outcome instruments would provide useful information for the development of an overall level of care system.
- Initial patient portal services have been implemented and the Wellness Centers will begin providing wellness and recovery information and resources more frequently using the patient portal.
- Continue to expand Client-Run Wellness Centers through contract providers to all Service Areas, with special focus where none exist.

RECOMMENDATIONS

- Provide sufficient technical assistance resources for both legal entities and the Electronic Health Record (EHR) vendors during the Integrated Behavioral Health Information System (IBHIS) go-live preparation and post go-live transition as the systems conversion is mission-critical for the department.
- Maintain the Chief Information Office Bureau (CIOB) and Central Business Office (CBO) staffing support at least at current levels during transition from Information Systems (IS) to the Integrated Behavioral Health Information System (IBHIS) until go-live on IBHIS is achieved for all providers and practitioners to ensure success in serving individuals timely and adequately.
- Investigate the feasibility of integrating both the MHP Human Resources and Central Information Office Bureau (CIOB) Help Desk units into the recently formed Health Agency organizational structure to further improve support for the MHP. As the lack of sufficient staff resources currently continues to impact the MHP's capability to provide timely support functions.
- Determine which Evidence Based Practices (EBPs) the MHP will continue to incorporate within its service delivery. Inform key stakeholders and initiate a training calendar.
- Create supportive staff training covering quality service and safety issues including:
  - Implement a Welcoming training for front desk/reception staff to utilize which supports quality customer service in a wellness and recovery-based environment. Provide culturally inclusive and cultural humility and sensitivity trainings system wide, include contract providers.

- Implement a staff safety refresher course in each Service Area secondary to the composition of the neighborhood concerns to enhance quality safety measures.

ATTACHMENTS

Attachment A: Review Agenda

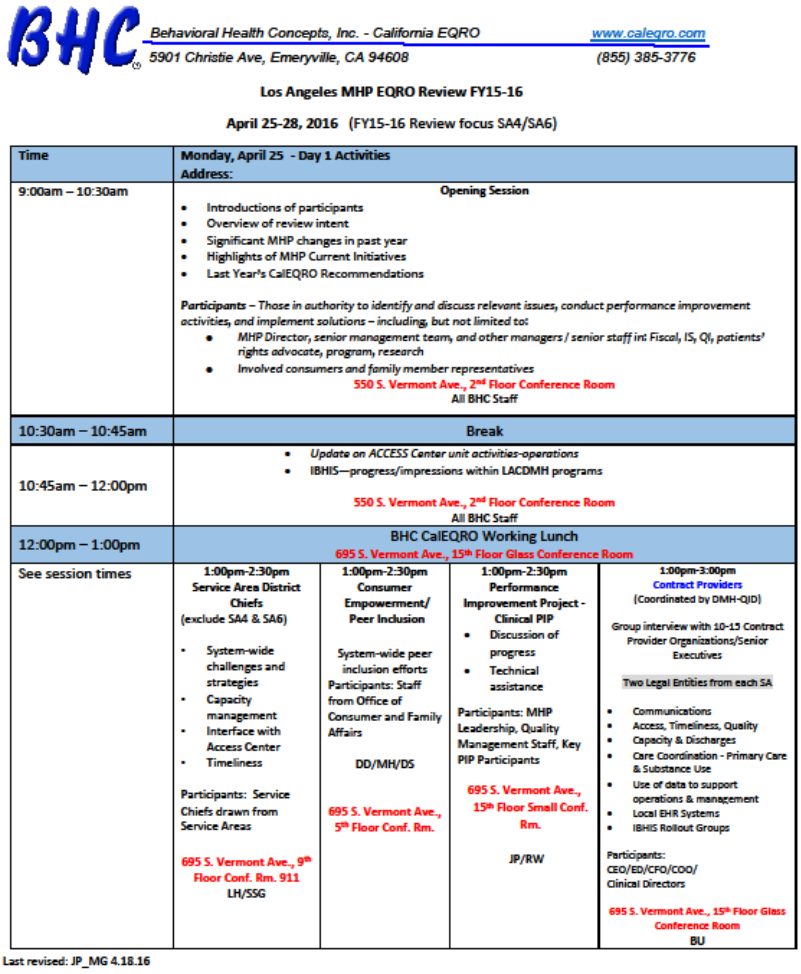
Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the MHP On-Site Review Agenda:



Behavioral Health Concepts, Inc. - California EQRO www.caleqro.com
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Los Angeles MHP EQRO Review FY15-16

April 25-28, 2016 (FY15-16 Review focus SA4/SA6)

Time	Monday, April 25 - Day 1 Activities Address:			
9:00am – 10:30am	**Opening Session** • Introductions of participants • Overview of review intent • Significant MHP changes in past year • Highlights of MHP Current Initiatives • Last Year's CalEQRO Recommendations ***Participants** – Those in authority to identify and discuss relevant issues, conduct performance improvement activities, and implement solutions – including, but not limited to:* • *MHP Director, senior management team, and other managers / senior staff in: Fiscal, IS, QI, patients' rights advocate, program, research* • *Involved consumers and family member representatives* 550 S. Vermont Ave., 2nd Floor Conference Room All BHC Staff			
10:30am – 10:45am	Break			
10:45am – 12:00pm	• *Update on ACCESS Center unit activities-operations* • IBHIS—progress/impressions within LACDMH programs 550 S. Vermont Ave., 2nd Floor Conference Room All BHC Staff			
12:00pm – 1:00pm	BHC CalEQRO Working Lunch 695 S. Vermont Ave., 15th Floor Glass Conference Room			
See session times	**1:00pm-2:30pm** **Service Area District Chiefs** (exclude SA4 & SA6) • System-wide challenges and strategies • Capacity management • Interface with Access Center • Timeliness Participants: Service Chiefs drawn from Service Areas 695 S. Vermont Ave., 9th Floor Conf. Rm. 911 LH/SSG	**1:00pm-2:30pm** **Consumer Empowerment/ Peer Inclusion** System-wide peer inclusion efforts Participants: Staff from Office of Consumer and Family Affairs DD/MH/DS 695 S. Vermont Ave., 5th Floor Conf. Rm.	**1:00pm-2:30pm** **Performance Improvement Project - Clinical PIP** • Discussion of progress • Technical assistance Participants: MHP Leadership, Quality Management Staff, Key PIP Participants 695 S. Vermont Ave., 15th Floor Small Conf. Rm. JP/RW	**1:00pm-3:00pm** **Contract Providers** (Coordinated by DMH-QID) Group interview with 10-15 Contract Provider Organizations/Senior Executives Two Legal Entities from each SA • Communications • Access, Timeliness, Quality • Capacity & Discharges • Care Coordination - Primary Care & Substance Use • Use of data to support operations & management • Local EHR Systems • IBHIS Rollout Groups Participants: CEO/ED/CFO/COO/ Clinical Directors 695 S. Vermont Ave., 15th Floor Glass Conference Room BU

Last revised: JP_MG 4.18.16

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price, Quality Reviewer Consultant
Bill Ullom, Chief Information Systems Reviewer
Saumitra SenGupta, Executive Director
Robert Walton, Quality Reviewer Consultant
Lynda Hutchens, Quality Reviewer
Della Dash, Quality Reviewer
Marilyn Hillerman, Consumer/Family Member Consultant
Deb Strong, Consumer/Family Member Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

Sites of MHP Review

MHP SITES

Los Angeles County Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Los Angeles County Department of Mental Health
695 S. Vermont Avenue
Los Angeles, CA 90020

Downtown Mental Health Center
529 S. Maple Avenue, Los Angeles, CA 90013

Augustus F. Hawkins
1720 E. 120th Street
Los Angeles, CA 90059

Hudson Auditorium
12021 Wilmington Boulevard
Los Angeles, CA 90059

CONTRACT PROVIDER SITES

Koreatown Youth and Community Center and
The Korean Family Services
3727 W. 6th Street
Los Angeles, CA 90020

Exodus Wellness Center
8401 S. Vermont Ave.
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Alma Romero		Pacific Clinics
Amber Bishop	MFTI	Enki Youth and Family Service
Amber Newman	Peer and Parent Partner	Hillsides FSP
Amy Virutamavongsa	Postdoctoral Intern/ Therapist	Alafia Mental Health Institute
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Carolina Covarrubias	Psychiatrist	West Central
Carolyn Brawn	PISA	CIOB
Carolyn Brown	Sr. Community Worker	Compton MH
Carolyn Chadwick	CEO	Tessie Cleveland Community Services
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Charlene Robinson	Peer Support	Pearl Ella Wellness
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Deborah Jackson	Peer Partner	Portals
Deborah Soto	MH Advocate	Compton MH
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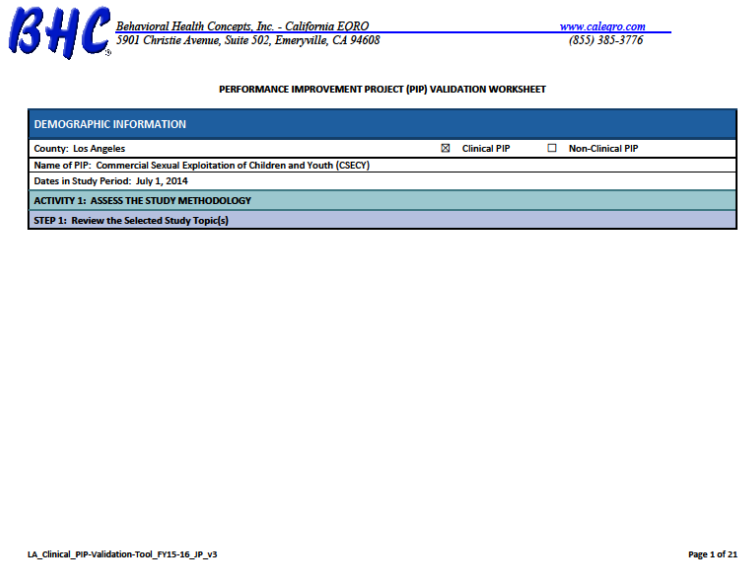
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP in a HIPAA-compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Los Angeles	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Commercial Sexual Exploitation of Children and Youth (CSECY)		
Dates in Study Period: July 1, 2014		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

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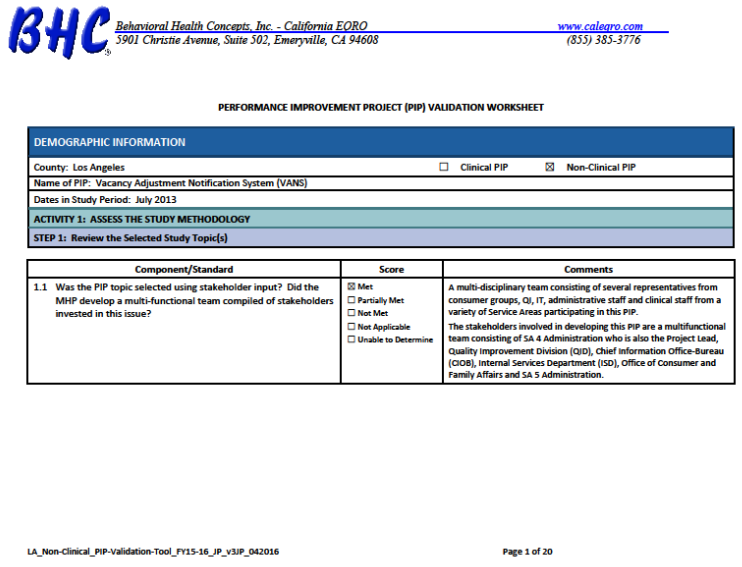
Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Los Angeles	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Vacancy Adjustment Notification System (VANS)		
Dates in Study Period: July 2013		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	A multi-disciplinary team consisting of several representatives from consumer groups, QI, IT, administrative staff and clinical staff from a variety of Service Areas participating in this PIP. The stakeholders involved in developing this PIP are a multifunctional team consisting of SA 4 Administration who is also the Project Lead, Quality Improvement Division (QID), Chief Information Office-Bureau (CIOB), Internal Services Department (ISD), Office of Consumer and Family Affairs and SA 5 Administration.

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